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THE GOVERNOR AND NATIONAL HEALTH INSURANCE:

A CASE STUDY OF POLITICAL DYNAMICS IN NEW YORK STATE

Michael Elihu Klein

1972

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The Governor and National Health Insurance: A Case Study of Political Dynamics in New York State

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Thesis submitted as partial fulfillment
of requirements for the degrees
Doctor of Medicine and Master of Public Health

Yale University School of Medicine

Department of Epidemiology and Public Health

1972

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INTRODUCTION

The now widely publicized movement toward National Health Insurance is a conglomerate of group proposed plans and protocols intertwined with widespread news commentary and governmental press releases. One begins to wonder about the origins of various ideas and also about the complex means by which information is collected, processed, and distributed. The desire to "change the system", to destruct and then recreate, is the ultimate goal of each of the plans even if "changing the system" means maintaining the status quo.

The problem undertaken in this study is to reveal the dynamics of one such group of individuals, in this case, the Rockefeller Committee on Social Problems (of which I was a full time member). The two phases to be examined are (1) the interactions of the committee with the movement toward a national health program and (2) the personal contributions of the committee's sixteen members.

Among the issues these problems present are (1) the political and economic interests of the committee and of its individual members; (2) influence exerted by Governor Rockefeller and to some extent President Nixon and staff; (3) in-

dividualism, bias, righteousness, and responsibility of individual committee members; (4) power structure of the committee including (5) decision making within the committee; (6) any group interaction and relations; (7) how the documents and decisions of the committee relate to the opinion and writings of the committee's consultants; (8) which issues were most prominent in committee discussions; (9) were those who testified before the committee representative of all health interest and were all given equal, unbiased treatment; (10) in relation to the committee's report; (a) who wrote it; (b) how was it written; (c) did the report reflect the content of committee hearings and/or personal feelings of committee members, and (d) how does the report relate to other evaluations of and solutions for the health crisis; (11) presence of time table and question as to whether report was rushed and also importance if any, of the timing of the release of the report; (12) effects of the report on current legislation and political processes both in New York State and at the federal level.

The background relevant to the current problem may be divided into four areas: (1) The longstanding interest of the Governor in health and health financing including his recent attempts at promoting universal health insurance in New York State; (2) the participation of the Governor's Steering Committee on Social Problems in the Arden House Conference in the fall of 1967 and the subsequent report and political effort

which led to the Family Assistance Act of 1970; (3) historical context of the current health crisis and current movement toward a national health plan; and (4) the dynamics of group interaction.

By far, the greatest number of references accompanying this proposal deal with number three, the current health crisis and movement toward NHI. However, no one may say the other areas have suffered from neglect. The bibliography includes several key reports by the New York State Joint Legislative Committee on Public Health, statements by the Governor, information from the New York State Office of Legislative Research, as well as personal interview material obtained on several different occasions during calendar year, 1970. Insofar as group interaction is concerned, Joseph Lufts' text on Group Processes has been quite helpful. In addition, I have relied on sources such as Ed Hall's The Silent Language and a 1967 text by Tom Harris entitled I'm OK, You're OK. A copy of the Arden House Report as well as hearings before the Ways and Means Committee, and group and personal discussions with other committee members has provided sufficient background of past activities of the Governor's Steering Committee.

Aristotle once said "man has an absolute moral right to such measure of good health as society is able to give him." It is apparent that our current modes and methods and money are not solving our ills. This study is undertaken to more

clearly understand the factors involved in changing the health care delivery system in the United States. It will hopefully emphasize that (1) the political realities of the system are not clearly related to what is best for the people; (2) that financial considerations are great; (3) that politics in terms of party goals and personality interaction are crucial and (4) that power is concentrated in the hands of a few who are largely influenced by political and personal convictions and that decisions are made in the context of and in accordance with broad political philosophies. The study is undertaken as well to more clearly define the modes of thinking, organizing, and lobbying of the chief executives of America's major corporations in the hope that information obtained might be applicable to similar groups meeting in the future.

The timing of this study is crucial. It is generally agreed that we now face a "crisis" in medical care delivery. Our health priorities are critically out of balance. Also, according to major figures such as Wilbur Mills, Chairman of House Ways and Means committee, there are going to be some major changes in our system of health care delivery within the next two-three years. It is my opinion that it would be most beneficial and contributory to examine the forces behind such change. Hopefully, we will find that there is, indeed, a method to our madness.

CHAPTER I

THE GOVERNOR AND HEALTH
AN HISTORICAL BACKGROUND

Introduction

> Government today is very flexible -- some of it is; some of it isn't. But government should be flexible, and it can be flexible, and government working with the private forces has the capacity in this country -- we have the resources, we have the intelligence, we have everything that is necessary if we know clearly what our goals are and then we have the understanding of how we can develop a system and the financing of a system and the participation of a community in the system that will be effective.
>
> And it will have to evolve; any living thing has to grow and change and evolve.
>
> Now I have been following this situation with a lot of interest for about twenty years and I haven't got the answer yet, and that is why I am so grateful to you for your participation. But I am confident that as a nation we are coming closer to it, that we are learning that we are absorbing and that this can be done.[1]

This statement was delivered by Governor Rockefeller before the New York Hilton Governor's Conference on Health and Hospital Services and Costs May 14, 1970. The conference was sponsored by the Governor's Steering Committee on Social Problems, chaired by Joseph Wilson, Chairman of Xerox Corporation.

The preceding September the Steering Committee had embarked on an eighteen month study on behalf of the nation's leading industrialists to earmark new directions and goals for American health policy. The optimism and energy of the committee's participants well reflected the stamina and persistence of the Governor despite numerous past defeats and rejections in the health care field.

The purpose of this chapter is to fully describe the Governor's involvement in health. Once this has been accomplished, the role of the Steering Committee in the Governor's health strategy will be carefully outlined. Certain questions come to mind. What interest did the Governor have in health? What was his experience prior to the appointment of the committee: Why did he appoint the committee: What did he hope it would accomplish?

The Governor's Health Background

By his own testimony the Governor's interest in contributory health insurance began in 1953 at which time he was Under-Secretary of Health, Education and Welfare for the Eisenhower Administration. At that time, he was deeply concerned that the nation's citizens lacked protection against "health catastrophe." He therefore urged private health insurance companies to collectively provide federally supported universal health insurance. They refused, but he remained convinced that "contributory health insurance was the best path to follow."[2]

It was by no means a coincidence that Nelson Rockefeller decided to run for the Governorship of New York State in 1958. The state had always been a harbinger of liberal and progressive thought, and had prided itself as a precedent setter in health and welfare legistation. Insurance in the public interest was not a new idea. Since 1910 employees had been required to have insurance for medical care and loss of wages caused as a result of work injuries.

The concept of mandatory health insurance in New York State did not arrive with the Governor in 1959. As early as 1945, majority leader of the Assembly, Irving M. Ives introduced a bill (A.I.2259) for compulsory health insurance. His purpose was not immediate passage but to serve as a basis for hearings and discussion and hopefully eventual passage.[3]

Similar goals were introduced the same year by Assemblyman Jack, Assemblyman Austin, and Senator Joseph. In 1946, the State Legislative Commission on Medical Care accepted the "insurance or pre-payment principle as the best way to make medical care available to all classes of people in the State of New York."[4] Legislation was not proposed because the Commission believed 1) more experience was necessary, and 2) was discouraged by what it believed would be formidable costs.[5]

In 1955, Senator George Metcalf of Auburn, New York, initiated studies of mandatory health insurance under auspices of the Joint Legislative Committee on Health Insurance Plans. In 1960, a bill (S.I.2586) was introduced which would have required mandatory health insurance for all employed persons

covered under the Disability Benefits Law. Employee contributions were up to 50% of individual coverage and 65% of family coverage with employers paying the balance. The bill died in Committee as did similar bills introduced yearly from 1962 to 1965.

In 1959, in his first annual message to the Legislature, the Governor indicated that "broad mandatory health insurance coverage"[6] would be a basic program of his administration. He proceeded to establish and direct what was to be called the Perkins Committee (officially, the Special Task Force on Catastrophic Expense Health Insurance) to consider the practicality of extending the Disability Benefits Law "to provide protection against catastrophic medical expenses".[7] The Disability Benefits Law already required employers of two or more individuals to carry insurance which would provide weekly cash benefits up to twenty six weeks of disability.

The Perkins Committee reported that it was technically feasible to develop a program of catastrophic medical insurance under the Disability Benefits Law but that it would not recommend legislation at that time (1960). The committee expected federal health legislation, commented that nine of ten workers already had some form of hospitalization insurance, and expressed fears that a mandated program "might have adverse effects on economic expansion and job opportunities in the state."[8] The Governor worked strenuously at the National Governors' Conference in 1960 and obtained a resolution support-

ing Medicare.

In 1964, when it became apparent that 1) Medicare and Medicaid were to be passed by the Congress, and 2) that the Metcalf bills were doomed, the Governor appointed a committee on hospital costs to examine and report on "the unremitting rise in the cost of providing hospital services". The committee was chaired by Marion D. Folson, Secretary of Health, Education and Welfare in the Eisenhower administration and was theretofore to be known as the Folsom Committee.[9]

Its April 1965 report criticized Article IX - C of the State Insurance Law which fostered artificial compartmentalization of insurance by prohibiting hospital or pre-payment plans from covering more than one area of health expense. It also disagreed with and invalidated the claim of the Perkins Committee that further study was needed prior to the institution of the Health Insurance Law. Folsom and staff recognized the inadquacy of existing pre-payment plans and the necessity of establishing a higher level range of minimum benefits to insure against health catastrophe.

The Folsom Committee recommended a nine-point program including a hospital insurance law for all employees (including the self-employed), grants and loans to construct and modernize efficient hospitals and health facilities and full payment of the costs of medical care for the indigent and the medically indigent. The committee also proposed a rational realignment of state agencies, repeal of restrictive provisions of Article

IX-C of the insurance law and moderation, and control of hospital care costs by more effective use of hospital and related health care facilities. The Committee's Hospital Insurance Law was notable for its 1) dependence on employer-employee financing, 2) administration by private carriers, and 3) coverage of unemployed workers.

A number of the Folsom Committee's proposals were included in 1955 legislation (the Folsom Act). The State Department of Health assumed responsibility for construction, improvement and operation of hospitals under a reorganization of public agencies. The Commissioner of Health was given authority to approve the construction of all new hospital and health facilities on the basis of public need as well as economical organization. To further moderate increasing hospital costs, the Health Commissioner was also required to certify the reasonableness and economy of insurers' rate schedules.

Other incentives for hospital cost control and economies were included in Governor Rockefeller's 1968 and 1969 Health Security Act (see later) and were to become law as an amendment (A 1760) of Chapter 184 of the 1969 legislation. Also, a constitutional amendment was adopted in 1969 which established a program of construction loans for voluntary and other hospitals which were regulated insofar as their profits and charges.

Both State Assembly Speaker Anthony J. Travia and Senate Majority Leader Joseph Zaretski shared the opinion that the passage of the Folsom Act and Medicare legislation "lent

urgency and need for legislative participation in the development and implementation of both Federal and State programs."[11] A one year study was conducted focusing on efficiency in the voluntary hospital insurance system and limitation of medical care available to the indigent and the medically indigent. Results were reported in March, 1966.

In its examination of health insurance the Travia-Zaretski Committee was distressed that those most unable to afford hospitalization were those without insurance. "Full coverage" offered by Blue Cross was incomplete, not applying to costly hospital services. Holders of commercial insurance policies were contracting for misleading cash benefits. Furthermore, government regulations had consistently ignored quality, volume, and means of coverage, concentrating only on financial soundness of programs. Most annoying, however, was the process of experience rating in which group premiums were determined according to projected utilization of services, thus discriminating against those with the greatest medical care needs.

To remedy these problems, the committee made a number of proposals. Most striking was their proposal for a system of universal health insurance for every member of the work force. Employers were expected to pay at least 50% of the costs and only Blue Cross could participate in the program. The commercial carriers were to provide supplemental coverage above and beyond the basic program. The latter was both contrary to the Folsom Committee Report and the Governor's subsequent health security

proposals. Indeed, the legislative committee was quite brusque with the commercial companies:

> It is believed that no great additional hardship would be imposed upon the commercial carriers by excluding them from the basic benefit market. It is hoped, in fact, that many of them would withdraw voluntarily, since the venture would become considerably less profitable for them.

The Travia-Zaretski Committee also suggested elimination of experience rating, with subsequent establishment of a uniform state-wide premium; a minimum uniform level of hospital benefits for all covered under the proposed universal health plan; and consolidation and supervised reform of the Blue Cross Program.

In summary, Rockefeller was very much concerned with health care, and, more specifically, with the politics of health care. By his own admission, his interests are traceable to the early 1950's.

He ran for Governor of a State well known for its liberal social reforms. Once elected, he strove to provide New York State with the most progressive health program in the nation. He appointed a series of committees to study and offer solutions to the health care problem. The Perkins Committee was reticent, but the Folsom and Travia-Zaretski committees both urged the enactment of a universal health insurance system based on employer-employee contributions. Other valuable reforms surfaced as well: 1) rational reorganization of state health agencies;

2) promotion of group pre-paid practices; 3) supervised and economical funding of State hospital construction; and 4) controls and incentives to promote cost efficiency.

Rockefeller was an opinionated but open minded individual. He openly expressed well defined ideas on most issues, but continually relied on the recommendations of advisory commissions. However, the committees he appointed often made recommendations which were consistent with his stated philosophy. It was a clever political strategy: appoint supposedly non-partisan, well respected committees to promote the passage of personally favored legislation.

Another of his predilections was evident at the start of his New York State political career. It was his constant interest and involvement in national health issues, policies, and politics. In 1960 he pushed the National Governor's Conference to support Medicare and throughout the mid-sixties publically supported the passage of Medicaid (see next section). The why behind this trend is not clear. Some have referred to this tendency as an uncontrollable striving. In any case, it led the Governor to run for the Presidential nomination in '68 and greatly influenced the functioning of the Steering Committee on Social Problems.

The Medicaid Fiasco

Meanwhile Medicaid (PL 89-98, Title XIX) was enacted by Congress in July, 1965. Upon enactment of the program the Governor called it "the most significant social legislation in three decades."[13] Legislative bickering over eligibility levels delayed approval of the New York plan until May, 1966. A struggle between Democrat Assembly Speaker Travia and Republican legislators resulted in the compromise enactment of a $6,000 base for a family of four. The latter led to a first year total Federal share of 217 million, an amount the Government had expected to pay for the entire country.

Hostility to the new legislation reached enormous proportions within a short period. As a result of the program's relatively high limits and concomitant expenditures, it became the chief focus of reform for the nation and the Congress. The advent of the 1967 Medicare and Medicaid hearings and the subsequent 1967 amendments were directly attributable to New York's flamboyance. Congress made it crystal clear that it had not intended Medicaid to be any more than welfare medicine. Local authorities were aghast since they would be paying at least one-quarter of the cost and would, as it came to pass, have to raise taxes as much as fifty percent. Employers, farmers, and medical groups all lobbied for repeal.

Initial Albany reaction was to either defend the new legislation or to turn a deaf ear on public reaction. The

Governor issued a statement protesting that experience had shown that only twenty-five percent of potential participants would sign up for the program.[14] He also claimed that despite increased eligibility both State and local authorities would save money.[15] He even appeared on television in an attempt to quell the public uproar. Anne Somers was to describe Rockefeller as a man "who has suffered more from the Medicaid confusion than any other Governor."[16] The Legislature held post-passage hearings to vent the disquiet and eventually passed a token one percent deductible for families earning more than $4500.

Simultaneously, an ad hoc cabinet committee appointed by the Governor called for urgent action. FY 1967 estimates projected a $78,000,000 surplus for the State. The result was $110,000,000 deficit. The Committee report concluded that "rising costs might threaten access to medical care for everyone in the State, including those who finance their own medical expense."[17] They called for a system of universal health insurance patterned along the lines of the 1967 proposal the Governor had introduced.

Even though he had gone on record as opposing the 1967 Medicaid amendments, the Governor admitted he had been mistaken in his enthusiasm and requested an eligibility cutback of 600,000. The political consequences of his actions were clear. It was another rejection of the individual citizen's rights and needs. In a private interview he remarked that

> Government cannot, in good conscience, promise and deliver a program, encourage citizens to sign up, and then snatch the promise and the program away. It breeds mistrust.[18]

It was obvious that legislating health care as a right, as was done with Medicaid, had not guaranteed the right. In a speech before Senator Ribicoff's Committee on Government Organization, the Governor stated,

> I did not regard Medicaid originally, nor do I regard it today, as the ultimate answer to guaranteeing the people's right to good medical care.[19]

He went on to state that Medicaid's failing was that it contained no self-restraining force - no direct contribution by beneficiaries - no personal stake in the system, and subsequently, there was nothing to curb abuse or excess expansion. Medicaid, according to the Governor, was useful as a second line of defense to help those who were having difficulty paying their health costs. The first line of defense was his proposed universal health insurance system.

The Governor had requested an eligibility cutback of 600,000. The legislature, responding to the people, chopped twice that number from the public rolls. Expenses continued to rise and another 200,000 were removed (July 1, 1969). In ad-

dition, coverage was eliminated for all those in the twenty-one to sixty-four bracket and a twenty percent deductible was placed on Medicaid out-patient treatment. Two years hence the legislators were still backtracking. Further eligibility cut-backs and cancellation of all payments for home nursing, drugs, physical therapy, dental care and eyeglasses were enacted.[20]

The rebound, as the Governor had predicted, was intense public dissatisfaction. A Federal Court in Brooklyn struck down the twenty percent deductible on out-patient treatment and the May, 1971 restrictions were blocked by injunction in Judge Irving Cooper's chambers (November, 1971).[21] In a landmark decision, the justice stated:

> The State's cutback had failed to meet Federal requirements for maintaining health services and reviewing medical cost of the program....New York's proposed plan compromises the very national interest which Congress sought to protect.[22]

The Governor realizing the legislature had gone "too far" pushed for restoration of home health and nursing services as well as transportation.[23] The impact on the 21-64 bracket was eased somewhat by the enactment of a catastrophic hospital cost provision.

The public's dissatisfaction was justified. Medicaid had been a fiasco. Ehrenreich writes:

> The residue of Medicaid, now that it has been cut to a near meaningless level, is the wreckage of the City's forty year old public health and hospital system. The City has less to offer, to fewer people, and at a greater cost, than at any other time since the depression.[24]

Access to new and increased services failed to materialize and the poor continued to have little or nothing to say about their destiny, programs on the whole being unresponsive to physical needs and insensitive to human dignity. For those who lost Medicaid there was nothing. They could not afford rising clinic fees which in some cases had soared as high as $16.00.[25]

Medicaid constituted a bitter defeat for the Governor. He had obviously spoken out too quickly. His program had been subject to the cruelty of nationwide intimidation. Even still, he avoided the aura of depression and/or defeat, instead utilizing the "failure" as a stepping stone type justification of the need for a system of universal nationwide health insurance.

Proposals for Universal Health Insurance

The Governor's interest in contributory universal health insurance dated back to the years of the Eisenhower administration. He had mentioned the idea in his 1959 inaugural and had been exposed to the recommendations of the Perkins Committee (1960), the Folsom Committee (1965), and the Joint Legislative Committee (1966). He viewed contributory universal health

insurance as a first line of health protection[26] and saw the failure of Medicaid as an opportunity to press his ideas. He stated:

> As for guaranteeing people access to medical care, no state has done more for its people than New York, and it will still be the leading state even after the Federal cut-backs in Medicaid this year. However, it is abundantly clear that the programs of publicly paid care, like Medicaid, will continue to be costly and difficult to control....I have consistently advocated health insurance as the best first line of health defense....the recently enacted cut-back in Medicaid highlights the compelling necessity for assuring our people the protection of universal health insurance.[27]

The 1967 Proposal

Thus, on the 22nd of February, 1967 the Governor issued a joint statement with major legislative leaders supporting

> a program of basic health service insurance for the great majority of employees in the state and their families based on recommendations of the Folsom Committee.[28]

It was the Health Benefits law of 1967 - one of five consecutive proposals for universal health insurance.

The 1967 proposal offered a limited scope of benefits: Semi-private accommodations for thirty-one days and in-hospital medical surgical costs with a $50 deductible and a 20% co-insurance. Payment was to be made to the extent that charges were "reasonable, necessary and customary."[29]

Eligibility was extended to employees and their dependents. Coverage was not required for those under Medicare. Employees with Medicaid and compulsory health insurance were required to use compulsory health insurance first. This was designed to reduce state expenditures under the Medicaid program since compulsory health insurance had greater controls.

The program was to be financed by equal employer-employee contributions up to a maximum of two percent of the employee's salary. The Governor chose this method of financing because of a firm conviction that it would 1) promote individual responsibility; 2) guarantee against government intervention; and 3) prevent unwarranted liberalization and run-away costs. Employee's contributions could be assumed by the employer via collective bargaining. Private insurance companies, including Blue Cross, would be the carriers. Those firms or employers carrying private coverage equal to or better than the program would satisfy stipulated requirements. It was estimated that annual premium costs would be $80 for an individual, and $230 for a family.

There would be binary supervision of the program: The State Department of Social Welfare via its Workman's Compensation Board and the State Health Department. The former would secure compliance by employers and judge on the adequacy of the employer's plans. The latter would supervise hospital standards and charges. In addition, the State Insurance Department would regulate premium rates and policy forms.

The program excluded part time employees, farm laborers, the self-employed and all employers with less than three employees, and, as mentioned previously, those on Medicare. There was no discrimination on the basis of age, race, religion or political beliefs. However, the number denied coverage was significant enough to make the plan less than universal. Under the plan, 400,000 would receive coverage for the first time and an additional 300,000 added surgical coverage.

Reaction to the 1967 bill was swift and severe and originated from both labor and business. Views of the business opposition were well represented by the statement of William J. Condon, special council for associated Industries New York:

> We are not so naive that we fail to recognize that the real purpose of this program is to shift the ballooning of Medicaid from the tax revenues on to the backs of employers and employees in New York State.[30]

Rockefeller did wish to rid the state of Medicaid costs and did admit that under the new bill employer costs would increase from $145,000,000 to $755,000,000. However, he believed that in the long run, costs for all would be less via the savings inherent in the legislation.

Labor was equally incensed. Raymond Corbett, President of the New York AFL-CIO stated in the New York Times, (March 7, 1967) that the bill had been mis-named and should have been called "The Insurance Company Benefit Law."[31]

Physicians, according to Dr. John Carter, of the New York Medical Society, opposed the legislation (Albany Times Union - December 5, 1967) because it "smacked of government interference and was compulsory."

A significant issue was that the bill was termed useless because over ninety percent of the population of New York State already had some sort of medical insurance. The argument counter to that was that the insurance they possessed was inadequate. But, even though 1,600,000 people would receive increased benefits under the new legislation, the resulting improvement would have been negligible.

Major legislative objections to the 1967 Rockefeller proposal were outlined by the Joint Legislative Committee on Public Relations and Medicare: 1) It was unfair to ask low income workers to pay for what they could obtain free through Medicaid; 2) "reasonable and customary fees" invited physician abuse; 3) the program was not and yet, should be truly universal in the scope of its coverage; and 4) the system should be financed, at least in part, by State revenues. They also supported the concept of experience rating which Rockefeller had publicly spoken against on several occasions.

Despite its opposition, the Joint Legislative Committee continued to support a program of compulsory insurance (A Cabinet committee [appointed by the Governor] simultaneously made the same recommendation). Its members recognized and sup-

ported what they felt were the beginnings of a widespread trend toward national health insurance. For New York such a system would 1) result in an estimated $210,000,000 annual savings; 2) prevent what Senator Tarky Lombardi, Jr. called "adverse effects on the economic climate and job opportunities in the State;"[32] and 3) promote individual dignity among its less wealthy citizenry.

The Governor himself was concerned about adverse effects on the State's economic climate as well. In a statement before Senator Ribicoff's hearings on health care in America, the Governor stated

> If it is a State plan as against a Federal plan, then we run the risk of having corporations leave the State for fear of rising costs or refuse to come into the State.[33]

He went on to state that limited percentages of employer-employee contributions would somewhat soften the economic effects of the bill, but reaffirmed the necessity of Federal legislation to bypass State to State competition.

The 1968 Proposal

To further soften the effects of Medicaid legislation, the Governor's 1968 health proposal (entitled the Health Security Act of 1968) contained significantly liberalized

benefits. One hundred twenty days of semi-private in-patient care was offered vs. the thirty-one days of the previous year. All in-patient care would be covered without deductibles or co-insurance and, in addition, one hundred days of home care and limited emergency out-patient services were added.

Coverage (1968 proposal) applied to all employers with one or more employees. Those employers whose existing health insurance coverage was equivalent to the proposed minimum standards would be excluded from the bill's jurisdiction for five years. The latter was designed to placate large firms in the State, most of which already had medical insurance coverage for their employees. It was felt the majority of small firms were local businesses who could not afford to move anyway. It was estimated that the 1968 legislation would apply to 14,000,000 individuals vs. the 5.5 million figure proposed for the 1967 bill.

Another major change in the 1968 legislation was State contribution of monies from the general tax revenues whenever the cost of coverage exceeded four percent of the employer's payroll. This was the Governor's answer to the accusations concerning the State's flight from Medicaid. Employees were required to contribute up to two percent of their wages but not more than one-half of the coverage. Estimated individual costs rose from $20 to $55 above 1967 estimates depending on rural or urban location.

The 1968 legislation contained a new section on hospital cost control derived from the findings of the 1965 Folsom Committee (see earlier). This also proposed that, with Federal and local assistance, the State would purchase health insurance for all those on public assistance and, at present, receiving Medicaid. Once again, the bill died in Committee.

On the Road

Following two defeats, the Governor began making trips out of State to gain support for Universal Health Insurance. He had testified before Senator Ribicoff's Hearings on Health Care in America in support of Federal universal health insurance with hospital cost controls, and at the same time, supported the principles and individual features of his 1968 Health Security Act. He repeated his recommendations at the December, 1968 Republican Governor's Conference and again at the December 23 Health, Education and Welfare hearings in New York City. Asked to make suggestions for Federal action before President Nixon's Council for Urban Affairs (February 12, 1969), the Governor included a proposal for national contributory health insurance. His efforts were rewarded when in March, 1969, the Committee on Human Resources (of the National Governor's Conference) suggested "national contributory health insurance be studied....as the first line of defense against rising costs of illness so that

publicly financed programs such as Medicaid may become a second line of defense."[34] At the Conference of Governors in Colorado Springs (August 31 to September 3, 1969) the Governor succeeded, by a wide margin, in convincing the Governors to pass a policy statement calling for

> adoption by the Federal Government of a National Universal Health Insurance program coupled with hospital cost controls as a primary method of keeping rising health costs for preventing all people from receiving the medical care they need. Such a program should utilize the existing private enterprise system. Publicly paid programs such as Medicaid should be used only as a secondary program for those who have used up their insurance benefits.[35]

The 1969 Proposal

On March 3, 1969, the Governor introduced the Health Security Act of 1969. It contained most of the features of the 1968 measure including a virtually identical hospital cost control feature. Benefits offered in the 1969 bill were less than those of 1968 but greater than that of 1967. Those covered would be eligible for ninety days of in-patient care. A deductible (of $44) was reinstituted as was a co-insurance clause which required that those covered pay $11 a day for every day over sixty days. In addition, a $15 deductible was added for out-patient diagnostic services. There were other minor changes made as well. Coverage was changed so that employers with three or more employees would be covered (much like the 1967 legislation). In addition, the program was to be supervised by a nine-

member Health Benefits Corporation headed by the Commissioner of Health. Significantly the 1969 bill included a plank which prohibited experience rating for groups of fewer than fifty employees.

The Hospital Cost Control Measure (part of the 1969 legislation) was enacted into law, not a part of the House Security Act, but as a separate amendment. (A-7160). Hospitals were required to establish a system of accounts and cost finding. The Commissioner of Health assumed responsibility for establishing rate schedules which were to be adhered to by government agencies and non-profit health insurance firms. The Commissioner was to insure that rates were "efficiently related to the costs of providing services."[36] He was to take into account variables such as geographic differential, economic factors, incentives from improved service, and economies and costs of hospitals of comparative size. The Commissioner was directed not to consider costs for research and educational salaries not directly related to hospital service.

The 1970 Proposal

The 1970 Universal Health Insurance Act was presented to the New York Legislature on 1 April 1970. There were significant changes present. Coverage was now required for all self-employed individuals with covered workers and all full-time employees (regardless of the number employed by their employers). Coverage was optional for 1) self-

employed without covered workers 2) the short-term employed and 3) Medicaid eligibles and public assistance recipients. The Governor gave up attempting to coerce Medicaid eligibles to drop the public program in favor of his Universal Insurance Plan.

Benefits remained largely unchanged. A $2.00 deductible was placed on all out-patient physician services. The financing of the program was made more specific. The amount paid was gradated as follows, (according to annual income):

ANNUAL INCOME	% PREMIUM PAID
Group 1 -- $6,000	35%
Group 2 -- $5,000 - $6,000	20%
Group 3 -- Less than $5,000	0%

Employers were required to pay sixty-five percent of premiums or four percent of payroll, whichever the lesser. The state would pay the residual fifteen percent of group two's premiums and all of group three's plus any excess above four percent of an employer's payroll. In addition, the state would finance fifty percent of the premiums of the short term unemployed. Federal revenues would cover the costs of Medicaid and public assistance eligibles.

The administration of the 1970 proposal was more complex than its predecessors. A corporation of twelve members, seven appointed by the Governor from "public groups", would

approve hospital and medical rates and fees, premium rates and insurance coverages; would administer state contributions to premium costs; approve pre-payment charges of group practice plans; supervise non-profit insurance corporations; and appoint at least seven regional medical councils. The councils, a new feature, were to contain nine members, at least three representing consumers and two purchasers of health services.

The 1970 proposal contained a new section on the organization and delivery of medical care. Legislation was proposed which was designed to stimulate the formation of non-profit group practice arrangements and other corporate forms of pre-paid care. Changes were proposed in Article IX-C of the Insurance Code (as suggested by the Folsom Committee) to eliminate statutory barriers so that physicians and hospitals could unite to provide comprehensive services on a pre-paid or fee-for-service basis. Furthermore, it was proposed that the new corporations be granted tax-free status and made eligible for state construction, modernization and start-up cost loans. The new non-profit corporations would be required to have consumer representation on their boards. Furthermore, the proposed health insurance corporation would be empowered to supervise the corporations and make recommendations on the quality, efficiency, and public responsiveness on services rendered.

The 1970 act also allowed for incorporation of any type of professional medical service under the business corporation law. Inherent in the proposed changes was quality and cost control via supervision by regional medical councils and the Corporation.

The 1971 Proposal

The Governor's 1971 legislative plans were outlined in a state of the State address on 6 January 1971. He reaffirmed his intention to reintroduce his universal health insurance program. His reasons for persisting were well-described in 1968 testimony before Senator Ribicoff's hearings of health care in America.

> I think with the federal budgetary problems that exist today, with the size of the deficit, that we, at the State level or at the local level can sit back and just wait for the Federal government to get out of Viet Nam and get some of these other problems straightened out, etc. I don't think these problems will wait. What we have been trying to do was to go ahead on our own and do as much as we could locally. I think most of this can be done.[37]

Needless to say, the 1971 Act, much like its predecessors, died in Committee. It was much the same in form and content as the 1970 Universal Health Insurance Act.

The hospital cost control provision of the 1968 and 1969 universal health insurance bills was enacted on its own as a separate amendment. Rockefeller's 1970 and 1971 universal health proposal contained a clause legislating

support for non-profit medical corporations. When it was clear that universal health insurance had failed again, the legislature agreed to consider the non-profit corporation plank by itself. The result was that the Medical Corporations Bill with bi-partisan backing passed the Assembly by a 100 to 23 vote on May 19, 1971.

Reactions from the Medical Care Community

Reaction to the Rockefeller legislation was mixed. As Anne Somers had noted, the bill excluded precisely those groups from compulsory coverage that most needed it.[38] She praised the bill for its attempt at combining "strong public supervisory authority with private underwriting."[39] She went on to recommend that the most effective means of achieving the latter was to limit the number of carriers allowed to participate in the insurance program.

Rashi Fein, commenting on the financing aspects of the bill, criticized the legislation for not taking into account the size of families and not realizing that with employer and employee contributions the total cost will, in the end, be borne by the employee. He was also discouraged by the limited benefits offered and the requirement that the individual would continue to have major private expenditures. However, in concluding his remarks he conceded, "It is difficult to assess how much better a single state could do."[40]

David Kindig in a paper entitled"The Impact of

National Health Insurance Programs on the Consumer" criticized the quality maintenance provisions of the 1970 act. He stated, "In short the Rockefeller Bill neither addresses nor meets the problem of quality maintenance."[41] In his paper he also criticized Rockefeller for not allowing consumer policy setting or even experimentation with the latter.

In reference to the latter, the Governor's views on community control have been widely publicized. On one occasion he explained

> If you are going to say community control -- that's really what you are shooting for -- the community as yet -- and this largely applies to the private communities -- are not sufficiently experienced or disciplined among themselves to actually be able to exercise control -- and I think that one of the tragedies of this era today is that community control has been given and has paralyzed effective action....I think that participation is essential but I question the word 'control'.[42]

Summary

This thesis could have very well been titled "The Governor's Struggle for Universal Health Insurance." The issue dominated Rockefeller's New York political career. As mentioned earlier, committee after committee endorsed the idea to no avail. Three essentially different models (1967, 1968, and 1970) were soundly rejected by State legislators. In progression, each had contained more sophisticated methods of administration, organization and

delivery; and quality and cost controls. Modification of proposals to satiate opposing viewpoints was equally unsuccessful. The Governor continually rode the national circuit to 1) give credence to the concept of universal insurance; 2) gain support for his state's proposal; and 3) lobby for the enactment of a federalized national health insurance based on his personal philosophies.

His strenuous but unsuccessful efforts quickly attracted national attention. He became known as the "father" of comprehensive planning and was clearly the first governor or major political figure to campaign actively for statewide universal insurance. This publicity further sparked his insatiable motivation to struggle for social reform despite continuous resistance, and innumerable setbacks and defeats. It is in this setting that we consider the Governor's Steering Committee on Social Problems.

The Appointment of the Steering Committee

The 1966 appointment of the Governor's Steering Committee on Social Problems marked the first time Rockefeller had appointed a state-based committee to study a national problem. His idea was to gather together an impressive, well respected and prestigious group which would have the capacity to make influential recommendations. It was a must that public recognition of the group's astuteness be inde-

pendent of its association with the Governor.

He initially chose eleven of America's top businessmen for the job. The chairman, Joseph Wilson, a close friend of the Governor, had recently retired from active leadership of Xerox Corporation. He, alone, had been responsible for the incredible success of this multimillion dollar enterprise. His rationale for stepping down prior to the age of sixty was to devote more time to his long-standing interest in social reform. The accomplishments of the other members of the Steering Committee were equally impressive. Each of the member's activities and accomplishments are fully described in the brief biographies appearing in Appendix B.

The director of the committee was Victor Weingarten. Mr. Weingarten, a brilliant organizer, was president of the New York City based Institute of Public Affairs. He was, by far, the one individual most responsible for the committee's enormous productivity. He briefed, contracted, and structured the input of the committee's consultants, planned and organized six committee meetings, two conferences and a Washington briefing with HEW chief Richardson and White House staff, and personally embarked on fact finding trips to the Pacific Northwest and the Soviet Union. Mr. Weingarten was well worth the $57,000 he received for his efforts.

The Steering Committee on Social Problems initially

had nothing to do with Rockefeller's struggle with health care issues. Its 1966 assignment was a study of the welfare problem, another of Rockefeller's pet concerns. The Governor (post-Medicaid) had become a dedicated spokesman for Federal financing and regulation of welfare programs.[43] Welfare and indigent health care were the two major financial drains on the State economy. In January, 1969 the Governor desperately stated: "We are now reaching the point at which the State cannot keep up with its needs in revenues."[44] The Steering Committee's spring, 1968 "Arden House" report is currently given credit for the genesis of the administration's Family Assistance Program.

The Governor, in the fall of 1969, impressed with the Steering Committee's welfare accomplishments and motivated by a nationwide surge for a national health insurance system (see chapter four), asked Joseph Wilson and the Committee to study the health crisis.

Wilson and Weingarten accepted and together worked out a strategy which called for an initial two day conference sponsored by the committee and attended by one hundred of America's most prestigious business leaders. The conference was to suggest guidelines which the Steering Committee (with five new additional members) would develop in a year long series of meetings and hearings. Following its investigation the Steering Committee would publish its report and, perhaps, reconvene the original conference to reveal and

discuss its findings and recommendations.

In summary, the Governor, impressed with the Steering Committee's success with the welfare problem, saw an opportunity to perhaps arrive at some new solutions to the health crisis and further promote national health insurance. As mentioned previously, he had traditionally relied on supposedly non-partisan committees to promote his personal philosophies. The Steering Committee represented his first attempt at using a personally appointed committee to further his interests at the national level. The latter, requiring good rapport with both the White House and HEW, was also a means of improving personal relations with the President and, perhaps, securing a desired cabinet position in the event of a Nixon re-election.

CHAPTER II

THE GOVERNOR'S CONFERENCE ON HEALTH AND HOSPITAL SERVICES AND COSTS

Background and Setting

The Governor had requested that Wilson and Weingarten conduct a study of the health crisis in the Fall of 1969 (refer to end of Chapter I). As outlined, their strategy called for an initial two-day conference to be attended by one hundred of America's top business leaders. They were to suggest guidelines which were to be the basis of a twelve-month study of the health crisis to be conducted by the Governor's Steering Committee on Social Problems. A final report would be issued and perhaps presented to the original conference for discussion. The members present at the initial meeting would not be bound to support the Steering Committee's final recommendations.

Planning for the conference was complex and handled mostly by Director of the Steering Committee, Victor Weingarten. Weingarten and Wilson, the "core nucleus" of the Steering Committee, chose four consultants to present position papers on various aspects of medical care.

Anne Somers' assignment was the broadest in scope.

She was to provide a summary of all aspects of the health crisis, review current proposed solutions for change and include a series of her own recommendations for solving the problems she and others had elicited. Dr. George Silver of the Urban Coalition was asked to submit a paper describing alternative means of improving nationwide health services and Dr. George Wolf of the University of Kansas was requested to address his comments to the complexities of manpower. In addition, Weingarten arranged for Herbert Lukashok of Albert Einstein School of Medicine to put together a series of statistical abstracts to serve as reference material for the use of the presumably uninformed businessman.

Weingarten secured the plush ballrooms of the New York Hilton as a setting for the conference. The best foods, hors d'oeuvres, and liquor were to be served in dimly lit, muted red velvet ballrooms. The business magnates, arriving in their chauffeur-driven limousines, would dine in an atmosphere most easily likened to that of a medieval royal banquet. The lords and barons of the business establishment would join together with their sire, the Governor, in an attempt to solve yet another modern day crisis.

Political notables attending included the Governor; Senator Javits; former Secretary of Health, Education and Welfare Wilbur Cohen; Majority Leader of the New York Assembly John E. Kingston; Chairman of the New York State Standing Committee on Health Senator Norman F. Lynch; New

York Assemblyman Francis P. McCloskey; Presidential Advisor Daniel P. Moynihan; White House Aide and Director of Urban Affairs Council John Price; Chairman of the New York Assembly Ways and Means Committee, Willis H. Stephens; and Senate Minority Leader Joseph Zaretzki.

A number of the most widely publicized figures in the health field were also listed. They were Anne Somers of Princeton; George Silver, National Urban Coalition; Associate Director of the Hospital Association of New York State George Allen; Dr. James H. Cavanaugh, Deputy Assistant for Health and Scientific Affairs, Department of Health, Education and Welfare; Lewis Butler, Assistant Secretary for Planning and Evaluation, Health, Education and Welfare and author of Medicare Part C; John Fox, Project Director, Hospital System Studies at the Battelle Institute; August Groeschel, M.D., Chairman of the National Health Resources Advisory Committee, Office of Emergency Preparedness (Executive Office of the President); New York Commissioner of Health, Hollis S. Ingraham; Director of Health Services, State Communities Aid Association, Edward G. Lindsey; Dr. Russell Nelson, President Johns Hopkins Hospital; Daniel Pettengill of Aetna (representing the Health Insurance Association of America); and George Wyman, Commissioner of the New York Department of Social Services.

The conference was publicized as being a meeting of

America's most prominent business leaders. Fifty-nine (seventy percent) of the eighty-four participants listed represented prominent members of business and labor. Of these fifty-nine, forty-one (sixty-nine percent) were listed as having New York addresses. Ten were previous members of the Governor's Steering Committee on Social Problems. A full thirty-one (or fifty-two percent) were either president or chairman of their respective corporations. Among the most prominent businesses represented were U. S. Steel, American Telephone and Telegraph, Standard Oil, Pan American World Airways, Hunt Foods and Xerox Corporation. A full list of conference participants is provided in Appendix C.

As might be expected, minority representation at the conference was negligible. There was one student participating: myself. It was felt that with my background in medicine and public health, attendance and participation would present me with a valuable opportunity to further my education.

The conference was not well publicized. A short notice appeared in the Washington Report on Medicine and Health in late January. No mention of the conference was made in either the AMA legislative report or the New York Times.

A schedule of events for the two days was published in April, 1970. The agenda for day one was light. There

was to be an opening reception and cocktail hour followed by a sumptuous supper. An evening session would include a welcoming address by Chairman of the Committee and Conference, Joseph Wilson, and summaries of the three major position papers by their respective authors. Dr. Wolf never did appear, leaving Anne Somers and Dr. Silver on their own. There was no evening discussion session planned.

Day two was to be more involved. The businessmen, politicians, and health professionals were to be split into three separate groups for three-hour morning workshops. Each workshop was to meet in a separate conference room provided by the Hilton. Instant service, whether coffee, tea, ice water, or pastries, was to be made available for the comfort of all. The three separate workshops were each to be provided with a series of five questions on topics ranging from health manpower to financing. The Governor and Staff and the "core nucleus" Wilson and Weingarten were to divide their time equally between the three groups. A tasty two-hour luncheon with ample liquor beforehand followed the A.M. session.

A meeting of the Governor's Steering Committee on Social Problems was scheduled for the latter half of the dinner hour. New members of the Steering Committee were to be chosen at the conference, officially welcomed by the Governor and later briefed by Mr. Weingarten. There was to be a short "pep talk" by the Governor but no formal or

informal discussion of the current proceedings. The events of the Conference were to be discussed at a June 22 meeting to be held at the New York University Club.

A 2:00 P.M. wrap-up session was scheduled in which hired journalists present at each of the workshops were to summarize the thoughts, discussions and decisions of the A.M. meetings. This was to be followed by a general discussion session and Governor Rockefeller's closing address.

Position Papers and Distributed Reading Matter

Those present at the conference had received a voluminous amount of literature, among which were the three position papers previously described. The most informative coverage was provided by Fortune magazine's January, 1970 work-up of the health care crisis entitled "Our Ailing Medical System." Other helpful publications were Business Week's "Sixty Billion Dollar Crisis Over Medical Care" (January 17, 1970) and David Hapgood's article entitled "The Health Professionals: Cure or Cause." The latter concentrated on the dictatorial, authoratative nature of the professional guilds. The guilds, through their control of state licensing agencies, had carefully restricted the supply of American medical manpower. Those health professionals produced were frequently theoretically overtrained and yet, unprepared to meet the challenges of patient care.

The businessmen present were effectively exposed to

the horrors of current "crisis" conditions. They were told of the misuse of scarce manpower, the maldistribution of personnel and facilities, the uncoordinated wasteful and over-specialized use of services, the astronomical rise in costs and the inability of the medical market mechanism to meet the burgeoning medical care needs of the people.

Of all the material, they were most impressed with the attempted analysis of the present system via the free market theory. It was appealing because of the businessman's understanding and familiarity with the frame of reference. The principles of supply and demand were not applicable to the health care system because: 1) there was little or no competition among physicians or hospitals, 2) hospitals were nonprofit, thus lacking efficiency incentives, and 3) the consumer, unable to gauge the quality of services could not make intelligent choices of physicians, hospitals or other of the system's multiplex components.

Those who had the time to read Anne Somers' nine chapter, one hundred seventy-five page work entitled "The Paradox of Health Care: Crisis Borne of Progress" were treated to an encyclopedic review of major health care issues as well as a stimulating discussion of possible, probable and suggested reforms. The theme of her text was the paradox of progress. She stated:

> It is ironic, but should not be surprising that widespread criticism of the health care establishment and financing mechanism had developed precisely at a time when such care is better and more accessible than ever.[1]

The main thrust of her text was the importance of and need for an expanded role for the hospital. Somers described the hospital as the technologically superior center of the health care system, extracting near total dependence, and yet unable to overcome its traditional passivity. It was plagued by diffuse management and numerous inefficiencies and unable to cope with multiple and evergrowing responsibilities and continually spiraling costs.

Despite its multitudinous problems, Anne Somers insisted that the hospital not be displaced from its central role in the health care economy. Planners should concentrate on efforts to develop strong and flexible internal organizational structures capable of acting upon and fulfilling new and expanded demands in an effective and economical manner.

Mrs. Somers envisoned a model in which the hospital would serve as a truly responsive center of an expanded community health care system. Carefully reasoned and sensitive planning and controls (quantatative and qualitative) would emanate from a university affiliated community hospital to a basically decentralized health care system. Hospital services would be increasingly decentralized to large numbers of neighborhood health centers, private group practices, first aid stations and home care programs in middle and upper class areas as well as poverty districts.

To coerce health care institutions to yield their past uncompromising insistence on autonomy, Somers suggested the "franchise" principle. The franchise, an expanded form of the hospital license, would be granted to those hospitals which fulfilled certain Federal and/or State guidelines for progressive change. The receipt of all Federal and/or State funding would be secondary to prior franchisement.

In summary:

> The hospital, as the broadest-based source of authority, in terms of professional, technological and financial resources, the site where professional needs and values and community needs and values meet and can be reconciled, will be assigned responsibility for assuring the essential functional and organizational relationships and the necessary qualitative and quantatative controls to make the whole complex system of community health services work on a predominantly voluntary basis.[2]

Mrs. Somers devoted a large portion of her manuscript to the issue of financing. She viewed national health insurance as an inevitable consequence of spiraling health care costs and recognized the resultant necessity of spreading costs over a broad population base. She argued convincingly for a "low keyed, educational, non-propagandistic approach[3] productive of a serious in-depth study, warning against the 'danger of promising more than the existing health care economy could deliver'."[4]

Anne Somers was quite excited about the possibilities of extending the Federal Employees Benefit Program (F.E.P.)

to the entire population. She praised the competitive benefits derived from limited participation of carriers in the program as well as the program's competent administration and effective minimum controls. Another agrument in favor of a F.E.P. type program was that it was more likely to facilitate significant changes in the health care delivery system. The program "appeared to offer greater possibility of both short-run cost-controls and long-run adjustments in the delivery system."[5]

While favoring the application of a F.E.P. type program, Mrs. Somers offered a list of five characteristics which she felt were essential ingredients of any national health plan.

1) Compulsory universal coverage of all not on Medicare.

2) Statutory provision for administrative regulation of benefits and premium rates.

3) Tri-partite financing with a large enough proportion coming from employees and employers to assure some actuarial and psychological connection between revenue and benefits and enough from general government revenues to assure coverage of the indigent and low income workers and to avoid the dangers of total reliance on a too-regressive payroll tax.

4) Underwriting by a limited number of private carriers, enough to insure meaningful competition among them and meaningful choice by consumers but not too many to assure responsible administration and economies of scale.

5) Competent federal administration directed toward planning and monitoring the system in the public interest.[6]

They were, with the exception of No. 4, quite similar to the principles embodied in the Rockefeller legislation.

Both her plea for adoption of a F.E.P. type program and her five guidelines for a national health policy involved reliance on the private insurance industry. However, Somers made it very clear that the use of the private sector in a national health plan would be clearly related to its ability to exert effective cost pressure on providers and to effect needed changes in the delivery of medical care. She suggested a number of immediate reforms for the private insurers: 1) elimination of the legal distinctions between hospital and medical services with greater emphasis on ambulatory care; 2) reduction of the number of carriers; 3) establishment of a uniform set of minimum benefit standards; and 4) elimination of costly duplicative coverage.

No matter what action was taken in regard to financing, Anne Somers took note of the importance of flexibility in view of inevitable change. She stated:

> Every solution creates new problems, often more difficult than the previous ones. No one living today is wise enough to be able to devise a system of health care that would be satisfactory for more than a few years.[7]

On this premise Mrs. Somers pushed strongly for the creation of a national council of health advisors:

> The most urgent need of all is for some competent prestigious body to keep the manifold problems of health care under continuous surveillance ...[8]

George Silver's paper entitled "Alternative Proposals for Improvement of Health Services Nationally" was largely concerned with the political realities of the health care system. Its essence was an ever increasing need for rationalization of existing resources. Massive financial infusions and radically new systems were not necessary. Numerous examples were cited. The monies saved from the expansion of group prepaid practice would far exceed cost reductions derived from improved hospital management.[9] Manpower would not increase with new funding because of "rigid professional conceptions of how and where physicians are to be trained."[10] Legislation, even with adequate funding, was subject to political influences from various constituencies which would attempt and often succeed at eliminating or diluting effective regulation. And so on ...

Of all the examples citing the need for increased rationalization, the most dramatic was Silver's denouncement of the fee-for-service pattern of payment. He claimed that any legislation permitting this method of provider reimbursement would further promote inflation. He explained:

> There is no good way of budgeting medical care costs, if physicians' service costs are unpredictable and their level left to the discretion of the providers themselves.[11]

The most attractive of Dr. Silver's numerous methods for promoting increased rationalization was his outline and description of the means by which existing Federal legislation could be theoretically adapted and reallocated to free thirteen billion dollars for promotion of progressive cost savers such as prepaid group practice and comprehensive planning. The Steering Committee, i.e., the "core nucleus" (Weingarten and Wilson) was so impressed with the latter that Dr. Silver was requested to further develop the concept at a future meeting.

Silver's suggestion for a national health insurance system involved three basic premises. The first was the use of Federal financial incentives to promote change. Hospitals introducing group practices would, for instance, receive increased capitation allowances. Second was the concept that a national health system would have to evolve. It would not happen all at once. Silver suggested several examples to illustrate how the latter would work. One could expand the network of neighborhood health centers as a first phase or institute a national health program for mothers and children, etc. The final point was the necessity of avoiding the private insurance carriers which Somers had supported. Dr. Silver rejected them outright in a criticism of the AMA's Medicredit program:

> Since only health insurance premiums will be deductible, the control of health service payments must revert to private insurance carriers, who have not yet shown any capability of controlling costs or supervising providers.[12]

The third position paper was George Wolf's "New Approaches to the Problem of Health Manpower." His main emphasis was that the medical manpower field was plagued by legislated restrictions. Physicians, motivated by fear of litigation, ordered excess diagnostic and laboratory tests, refused to delegate authority to physician surrogates and operated with a huge overhead due to enormous malpractice insurance costs. Similarly, he outlined a whole order of adversities produced by the absence of vertical mobility in the health field.

Most interesting was Wolf's description of the doctor's critically needed non-medical functions. He stated that although the physician's role had changed dramatically in recent years, elements of religion and its attendant emotionalism still abound in today's society.[13] The modern doctor was a dressed-up witch doctor, adorned with magic instruments and invested with mysterious powers of healing.

The literature received by conference participants was on the whole neither conservative nor radical. It concentrated on reforming the present system rather than starting anew. There was an urgent need to reorganize things in such a way as to promote increased rationalization. The papers thus promoted the view that the American people were not receiving their money's worth. The medical profession, left to discipline itself, had totally failed to consider the sociologic and economic aspects of medical care and had,

furthermore, constructed a bulwark against change to protect their financial interests. Hospitals, private insurers, the government, business and labor were all indicted for their failure to intervene but in a sense reprieved because of former sociologic taboos against interfering with the "doctor-patient relationship." The papers viewed national health insurance as inevitable but cautioned against radical changes in the system over a short time period. The need for careful study, planning, and evolutionary reform were all stressed.

The Thursday Evening Session

The Preliminaries

The conference began at 4:00 P.M. Thursday with registration, a cocktail hour and dinner. Most of the participants arrived close to 4:30. They were all elegantly dressed in conservatively fashionable custom-tailored suits. For the average citizen, being present was an awe inspiring experience. Everywhere one turned there was another well known personality that you had either seen or read about in the New York Times or national news media. In general, the businessmen were unbelievably open and friendly and quite anxious to make new acquaintances. The "core nucleus" (Weingarten and Wilson) carefully welcomed each guest and spent a good amount of their time making introductions and starting conversations.

Most of the small talk during the cocktail hour and

dinner concerned either business matters or the student revolt. A large number of the executives were concerned about the brutal attack on New York City students by Wall Street construction men.

There was relatively little discussion of the health crisis. A number of businessmen present remarked they hadn't had the time to read the distributed material. Others commented they had read some of it before retiring the night before or had done some speed reading on the train or airplane. All expressed a genuine interest in learning about problems of the health care industry while simultaneously expressing their ignorance on the subject. They were, as a group, characterized by their ability to extract information from others on subjects in which they were deficient. They were low keyed, usually suggesting and questioning ideas rather than authoritatively stating a position. Their stance was one of maximum receptivity.

By the end of the cocktail hour, most present were relaxed, verbalizing their opinions more freely and quite ready for the appetizing six course roast beef dinner to follow. All appeared to be in excellent spirits for the 8:00 P.M. plenary session.

The Thursday Evening Plenary Session

The Thursday evening plenary session consisted of an opening speech by Chairman of the Conference, Joseph Wilson,

followed by summaries of position papers submitted by Anne Somers and George Silver. Joseph Wilson's opening speech was a layman's introduction to the health care crisis and an explanation of the role the private sector, and in this case business and management leaders, was expected to fulfill. He invoked authority for the investigation both from the Governor and the President. He mentioned that at a July, 1969 White House meeting, the President, Secretary Finch and Assistant Secretary for Health and Scientific Affairs, Dr. Roger Egeberg had called attention to "the breakdown in delivery of health care." At that time they called for concerted action by government and the private sector.

Mr. Wilson quoted from a recent article in Fortune Magazine's "Our Ailing Medical System" to illustrate the keynote of the conference:

> The financial distortions, the inequities, and managerial redundancies in the system are of a kind that no competent executive could fail to see or be willing to tolerate for long...nobody except other physicians should tell physicians how to practice medicine. But the management of medical care has become too important to leave to doctors, who, after all, are not managers to begin with.[14]

The managerial proficiencies of the business executives was justification for their intrusion in the health care crisis. It quickly became a landmark--an effective psychological crutch for any insecurities anyone present might have had in trespassing on heretofore forbidden territory.

He emphasized the importance of economics of medicine and singled out the personal interests of employers in health care, i.e., that of their employees, families, and customers. To illustrate the rapid rise in medical care costs, he used the example of one of the conference's participants whose company's insurance premiums had risen $20,000,000 in two years.

The goals of the conference were limited. Most of the work would be done by the Governor's Steering Committee over a one-year period. "There would be no resolutions, no ten-point programs." What Mr. Wilson expected was to 1) educate those present, 2) air the major issues, 3) define basic goals and 4) receive direction as to what resources must be applied to achieve the stated goals.

Chairman Wilson was a confident and forceful speaker with an incessant smile. He impressed those present with the sincerity of his concern for social reform and by virtue of the latter tended to motivate an interest in health among his audience. His adeptness as a speaker was well reflected by his captive audience.

Following Mr. Wilson's speech, Anne Somers and George Silver were asked to summarize their position papers. Their talks were straightforward resumés of the documents which had been distributed. Virtually no new information was introduced.

Mrs. Somers' presentation was an eloquent, carefully

reasoned, detailed account of her manuscript. She briefly outlined her conception of the paradox of health care and then spoke at length about her "hospital" and "Financing" models. Somers' oratory, much like her prose, consisted of a rapid sequential series of highly interrelated concepts. Each statement flowed smoothly from its predecessor to its successor.

The businessmen were generally impressed with Mrs. Somers, but desired additonal time to review and discuss her proposals. They were quite reluctant to express opinions or make commitments. However, it was obvious that the stress on private interprise vs. public domination appealed to the group of business magnates. Several of those present made reference to Edgar Kaiser's (Chairman of the Board, Kaiser Foundation) quote, extolling the attributes of private enterprise.

> With ingenuity and imagination government participation can be so organized that it will not defeat, but will support those aspects of the voluntary insurance structure which are so advantageous to the character of our socio-economic system and our country's people as a whole: the assurance of free choice to the consumer of health care, and encouragement of competition among providers of service.[15]

Dr. Silver elicited frequent laughter with his crafty, calculated and sometimes sarcastic comments. His focus on increased rationalization of existing services also appealed to the economically minded group who, in general, were also adverse to the government intervention inherent in radical

change. Silver's proposals offered highly practical solutions to complex health problems. They did not, however, address the means of overcoming Congressional and administrative inertia and resistance.

Interestingly, a significant number of individuals at the conference rationalized the massive factual data they were exposed to by comparison with personal experiences either with family or industry. They often cited unfavorable experiences they themselves had had with physicians or talked of their past myocardial infarctions or tumor operations.

The Friday Morning Workshops

The agenda for the morning of Friday, May 15, was the discussion of a specied list of problems and questions in workshop sessions. As described, the conference was divided into three equal groups, each with a pair of consultants, representatives from the Governor's Steering Committee and a journalist. The journalist was responsible for summarizing the morning's discussion and reporting his findings to the afternoon post-luncheon conference at which the Governor was the main speaker.

The Governor was present the entire morning and spent his time rotating between each of workshops. He participated actively in the discussions, exhibiting a first class knowledge of the issues and suggesting varied solutions to each

of the problems presented. His presence stimulated discussion, enlivening each of the topics upon which he commented.

A list of questions formed the nucleus for the morning's discussion. The first question was whether or not there was a current crisis in the system of health care costs and delivery. Governor Rockefeller, speaking to Workshop A, of which I was a member, commented he felt there were three crises: One, the individual had run out of money; two, financing was poorly thought out and grossly inefficient; and three, Medicare and Medicaid (but mostly Medicaid) would lead to a bankrupt society.[16] In general, however, the businessmen present were reluctant to use the word 'crisis'. In the words of Penn Kemball, Professor of Journalism from Columbia,

> The word 'crisis' has lost credibility. They (the businessmen) would just as soon not escalate the rhetoric but define the problem and come up with ideas.[17]

Thus, the mood was one of practicality. The businessmen recognized the gap between the potential and the current reality of the health care system, and wished to press for immediate effective action.

The second issue was the question of whether comprehensive health services for all was a basic right. This idea had been suggested as early as twenty five years ago by the World Health Organization.[18] It was an interesting point to discuss since the government had proclained the

"right" to comprehensive medical care in PL 89-749 in 1966. The stated goal was "to assure comprehensive health services of high quality to every person."[19]

The Governor reiterated his position (see Chapter I) that it was both disappointing and frustrating to the poor to legislate rights that government found impossible to deliver. He commented that the delivery of health services to all was more a "moral question" or "moral responsibility" than a legal right.[20] Others unquestionably accepted the phrase. Harvey Russell, of Pepsi Cola, stated "It is a legal more than a moral right of every American to good and adequate health care.[21] Another suggestion offered by New York Commissioner of Health, Hollis Ingraham, was that the right was not to comprehensive care but to equal access to medical care.[22]

William Edgerly, Financial Vice-President of the Cabot Corporation, was more concerned with ends rather than means. Whether or not health care was a right or moral obligation did not affect the feasibility of change or the degree of sophistication in accomplishing that change.[23] He stressed that we not attempt to "light fires under rights since these rights would subsequently turn into demands."[24] What was important was improvement of present performance.

There was not much consensus on providing comprehensive care to all people. There was agreement that provision of a program of humanly minimum benefits was more practical. The level of benefits offered by Kaiser Permanente was suggested

by Workshop C as a guideline. It was hoped that such a program would emphasize ambulatory care and include preventive and emergency care measures as well.[25]

The next issue involved the structure and functioning of the present medical care system, specifically requesting suggestions for change. There was widespread endorsement of a comprehensive prepaid group practices similar to the Kaiser-model as the most satisfactory method of delivering health care. Many of the benefits of group practice were alluded to including increased cost accountability, greater receptivity to allied health personnel, emphasis on ambulatory services versus expensive hospitalization, and the facility of including preventive rehabilitative services.

Even though the consensus was for group pre-paid practice, the importance of offering several choices to consumers was mentioned by several participants.

Workshop B under the consultant tutelage of Martin Cherkasky of Montefiore Hospital picked up George Silver's contention that the fee-for-service remuneration system was an evil focus of the problem and had to give way.[26] Others were more content in providing competitive reimbursement schemes with incentives towards reimbursement mechanisms other than fee-for-service. Philip Klutznick, member of the Governor's Steering Committee answered to Cherkasky by stating the reality "that changing fee-for-service system was easier said than done and it (fee-for-service) had certain merits".[27]

There was strong input favoring the injection on

"managerial sense" into the health care system. Governor Rockefeller called for a "systems analysis approach." First define goals - what is to be included in the system and then design a system which will satisfy needs and at the same time satisfy federal guidelines. The real problems, he concluded, were organizational.[28] The Governor went on to emphasize the need for continuing basic research into the delivery of health care by provision of necessary grants and start-up costs.

Harry Cunningham of Kresge and Company agreed and suggested use of full computerization (data processing), uniform accounting, and common purchasing.[29] Avery Raube of the National Industrial Conference Board was also "heavy" on administrative controls and the necessity for establishing and enforcing "standards of performance."[30]

The other major issue stressed, besides that of community controls was that of accessibility to the health care system. The question was nicely phrased by Assemblyman McClosky who asked how the patient could "identify where to go - the system is so over-structured."[31] William Edgerly stressed the importance of choice while George Silver commented on his plan to increase the number and availability of neighborhood health centers. Group C, under Anne Somers' direction, came out for a health care system centered about the hospital much in the same way and for the same reasons as described earlier in this chapter.[32]

She indirectly referred to a plan proposed by Ray Brown, Exdcutive Vice President of Northwestern University Medical

Center and former President of the American Hospital Association.[33] In Mr. Brown's plan the hospital was the port of entry into the health care system, much as it is today, but a rationalized organized system replaced the emergency room. The hospital maintained all patients' records in a given area, transferring records with the patient as he moved from location to location. The hospital also was responsible for providing the patient with a physician who secondary to his close affiliation with the hospital maintained records which were fully co-ordinated with hospital in-patient records.

The businessmen present, including the Governor, were most anxious to discuss the financing aspects of a medical care system. Perhaps the most significant remark was that financing could not be considered without including organization, delivery and manpower. Most readily agreed with the consultants on this point. The denouncement of fee-for-service mechanism (Group B) was discussed earlier.

To a large extent, the businessmen present favored the adoption of voluntary payment mechanisms. They pointed strenuously to the need for strict administration and regulation at the Federal level by means of the totality of modern devices and systems for cost bugeting and accounting. Thus, an intermix of private and federal financing with emphasis on accountability, inovation, experimentation and especially competition was the prescription offered.[34] They had had misgivings about the waste and inefficiencies inherent in an open-ended system such as Medicare and were waiting for oper-

ational improvements before endorsing any new and expanded means of financing such as National Health Insurance. An enlightening suggestion from Workshop C was that protection against the astronomically high costs of malpractice be exchanged for strict adherence to specified quality control provisions.

Chairman Joseph Wilson stated that government had missed a valuable opportunity to organize the medical profession with the monies used to finance Medicare and Medicaid. He cited the power of Federal monies when used incentively and ingeniously. He stated that with new plans and Federal monies you "could get anywhere. It is the kind of clout that will change the system."[35]

The manpower issue was the final topic considered and, in one case, superficially at best. As Penn Kimbell of Columbia School of Journalism commented:

> The manpower problem - we didn't get into this because our moderator in his wisdom, decided to put manpower at the end and therefore he knew we would never get around to manpower.[36]

Much ado was made of the concentration of doctors on Park Avenue and the scarcity of medical manpower in Harlem, just a few miles away. It was suggested that there should be greater use of local community hospitals for teaching purposes, preceded of course by affiliation of the latter institutions with university hospitals. Students would re-

ceive basic science training in the university setting and then enter in much increased numbers an organized educational network of university and affiliated community hospitals.[37]

It was also mentioned that financial incentives should be used to correct distribution patterns and to funnel physicians into specialities where the needs were the greatest.[38] The new family care specialty was mentioned. Anne Somers had mentioned in her manuscript that Pennsylvania State Medical School, which specifically emphasized family medicine, received two thousand applications for forty-eight available positions. This, however, could be due more to the desire to get into any United States medical school (a near impossible feat in 1972) than the impetus toward family medicine.

Speaking for Workshop C, John Hamilton of the Editorial Board of the New York Times, nicely summed up the essence of the businessmen's feelings:

> There is a crisis, or at least a desperate problem. It goes deeper than money. It goes to the structure of the health care system. There is a need for fundamental reform. There should be some system of comprehensive prepaid group practice insurance and in the meantime some changes and reforms in present insurance offering which would promote an expansion of care and moderation of costs.[39]

As they went to lunch, the business executives present were all discussing the health care issues of the A.M. workshops. They had not proposed any solutions or formulas. They had decided that the main problem in the health care field was lack of organization. Easy accessibility to a system

organized on sound principles of business management with maximum cost accountability would have to form the foundation of any solution. There was an emphatic plea for maximal competition and free choice for the consumer whether the subject was provider reimbursement schemes or methods of financing. These were the principles on which the Steering Committee's year long study would be based.

The Friday Afternoon Steering Committee Meeting

As originally planned, a meeting of the Steering Committee on Social Problems was held during the luncheon hour. Its purpose, as described earlier, was in informal get together to welcome new members and to receive a brief "pep-talk" from Governor Rockefeller. There was no discussion of health issues of the proceedings of the conference.

The meeting took place in a small waiting room on one of the upper floors of the New York Hilton. There were no chairs and all present stood and chatted informally until the Governor arrived. Five new members had been chosen to join the original core of eleven which had been formed to study the welfare issue (see chapter I). They were Harry Cunningham (Kresge and Company), Joseph Dallas (E.I. DuPont), myself, R. Heath Larry (U.S. Steel), and C. W. Owens (A.T.T.). The method by which they were selected is unknown. They had been invited to join the Committee during the initial portion of the Friday luncheon.

The Governor arrived and was introduced to each of the new members of the Committee, chatting briefly with each of them. He had a unique way of greeting people. He would move within inches of the person, violating so-called "body space", grasp their hand, smile and wink all at the same time. Its effect was overpowering. The Governor expressed confidence in the committee's ability, stressed the difficulties he had experienced in the past and wished us success in our efforts. He stated his wish for effective solutions to current problems and reaffirmed his intention to use the committee's recommendations as a basis for new state legislation.

The Friday Afternoon Plenary Session

The Friday afternoon conference was in essence a summary of the morning workshops followed by a general discussion and a closing speech by the Governor. The issues and commentary of the A.M. conferences requires no further discourse.

The discussion section focused its attention on a few major issues. The first was the feasibility of applying a Kaiser type program to the entire country using present resources (manpower and facilities). Dr. Peter Warter, a department manager at Xerox, stated that his computations based on per capita cost, physicians per 1000 beds per hospital, et cetera, showed that in each instance the resource to population ratio for the country was considerably higher than

the Kaiser plan. The importance of making this computation was the need to redirect resources based on the recognition that society was only going to tolerate the allocation of a certain maximum level of money for health. Both Dr. Silver and Mrs. Somers agreed with Dr. Warter's estimates, but Anne Somers warned that Pete Warter had overstated the ease with which reallocation could be accomplished.

Philip Klutznick, of the Steering Committee, amplified Mrs. Somers' position. He stated:

> I am a bit suspicious of easy solutions to public problems and the business of matching what is happening in one area of the country with the national situation.[40]

He cited that the Steering Committee had had more precise statistics than offered by Kaiser for the welfare issue but that things did not work out "because in a free society people don't respond to statistics quite as easily as we do in a meeting of this kind.[41]

Mr. Klutznick joined the Governor in stressing the importance of coordinating organization and financing because "how much it costs depends on how you organize."[42] The point had been made that Kaiser was primarily a middle income plan, covering people who are the best risks. The Governor repeated that it did not matter "whether it's a middle income group or a low income group because the financing had to cover everyone."[43]

Doctors came under attack by Dr. Warter. He remarked that their power position was secondary to their short supply and commented that doctors were needed for only two reasons: "We need more doctors so that we will be able to deal with them and not be obstructed by them anymore."[44]

The response to this comment was laughter but the naked truth of the statement was stunning. Philip Klutznick came to the defense of the physicians by stating they were not present to defend themselves, and that if given a chance 90% would enter into the discussion and offer constructive influences.

The issue of the community was developed by Steering Committee member Samuel Silberman. He stated that although the necessity for community involvement was recognized, no one had figured out the 'how to do it.' Mr. Silberman's concept of implementing the idea was to start with a satellite community clinic with one doctor. The community would control the clinic and dictate to the hospital instead of vice-versa.

Martin Cherkasky, progressive director of Montefiore Hospital, had had a great deal of experience with this issue. He cited the difficulties involved and the discouragement experienced after as he put it having "your teeth kicked in."[45] He continued to emphasize the necessity for community participation and even community control backing up his contentions with the statement that "After all, a control of its own social institutions by the society, that's what democracy is all about."[46] He pleaded with those present to allow for mis-

takes for the latter was a necessary consequence of the learning process.

Other opinions were not so generous. The Governor, denounced the community as not being sufficiently experienced or disciplined and had, as a consequence, paralyzed effective action. He agreed that community participation was essential but questioned control.[47] Joseph Wilson summarized a personal experience Xerox had had with the community. The company had established a small private minority enterprise and had permitted the community to totally man and operate the business. The results were disappointing. "Sponsorship changed and immediately all the employees changed. We just couldn't make any money out of this, hard as we tried."[48]

Before introducing the Governor for his closing remarks, Chairman Wilson thanked everyone present for their contributions. He commented that the timing of the study was nearly perfect. He implied that federal proposals for legislative change in the health care system might follow the committee's report much as they had the Arden House report on the welfare system.

The Governor's closing remarks were brief. He was extremely grateful.

> I don't think I have ever listened to panels where people were more willing to express themselves and more imaginative in terms of the possibilities and approaches which could be used.[49]

He commented that for the individual in need, lack of medical aid would indeed constitute a serious crisis. He reiterated the importance of recognizing the inter-relation of organization and financing and personally expressed his desire to see everyone covered by health insurance. He called it the American way of life: "That you put aside a little regularly so as to protect yourself in the eventuality of an illness or an accident or whatever it may be."[50]

He hoped that insurance would stress out-patient ambulatory care so as to avoid expensive hospital costs. The Governor pleaded for contributions by beneficiaries to insure against political interference and to promote individual responsibility.

His biggest worry was also that of Anne Somers': that the push for a national health insurance system would snowball and that according to the Governor:

> We will rush into some ill-conceived plan that really hasn't been thought through and that is going to result in the same kind of thing we had, only on a larger scale, when they put through Title XIX.[51]

The Conference officially ended with the conclusion of the Governor's address. Supposedly, its purpose was to provide a base from which to launch the Steering Committee on Social Problems' year long study of the crisis in health and hospital costs and services. A number of basic principles had been suggested by the Friday morning workshop sessions (see earlier). However, the conference was most important as a front--a public

relations stunt. It attracted attention to the health crisis, but more importantly to the Governor in an election year. What could be more logical than to have the best of American industry join together to help an ailing brother.

CHAPTER III

FUNCTIONING OF THE STEERING COMMITTEE I
THE HEARINGS

Introduction

In Chapter I the Steering Committee was described in relation to Governor Rockefeller's political and health goals. The genesis of its current study was the subject of the second chapter. The principles upon which the committee was to function had been outlined by the Friday morning workshops. The next two chapters concentrate on the functioning of the Governor's Steering Committee. The first is a description of the committee's meetings and hearings. The second concentrates on a discussion of group behavior and group dynamics.

To facilitate understanding, a system's analysis approach is used to outline the scope of this chapter. The processing unit is the Steering Committee. The input is a multifacterial entry-mix. It includes the Governor and staff, testimony and writings of the consultants as well as that group asked to testify, the literature distributed and the commentary and gestalt of the May 14-15 Governor's Conference.

The input interacts with the processor. The structuring of the processor is more subtle and involves consideration of the dynamics group processes. The output, the committee's report is discussed, in detail, in Chapter V, in all aspects including its influence on the politics of health care in America (Chapter VI).

The next two chapters are concerned with the input and the processor. Several questions come to mind: What is the input? Is there a regulator of flow into the system? If so, how does the regulator function? How does the flow that is excluded differ, if at all, from the entry-mix. What are the mechanics of processor functioning? Also, what were the overt, hidden and acknowledged purposes behind the study? What, if anything, was the Steering Committee supposed to achieve? An examination of committee functioning will enable us to determine the independence of committee action and thought. Was there any relation between committee function and the May Governor's Conference? If so, what were the similarities and differences between the Conference guidelines and gestault of the hearings?

In order that we may see "the forest through the trees" our analysis of committee functioning must be based on a suitable model. It is quite easy to invision how the barrage of facts, opinions, and theories could distort any discussion of committee operation.

The ideal committee should be totally independent, free to delve into the issues under concern. Members should be

selected such that they represent a cross-section of differing backgrounds and are thus able to provide varied perspectives on the issues at hand. No one interest or group of interests should dominate, for fear that this will monopolize and control committee thought and opinion. The committee members should be free from conflicting interests with government or other sources of power.

Mechanisms should be established which permit maximum objectivity. Committee opinions and comments should be carefully sought on all major issues. Consultants to the committee should reflect the gamut of opinion on the issues at hand. They should each provide succinct analyses of their opinions which should be distributed among all committee members. They should not be allowed to dominate hearings for fear that they too will suppress and control committee thought and opinion. These testifying should present the full range of alternative theory and solutions to the current problem. They should be allowed to develop their philosophy in a supression-free atmosphere. Both these testifying and the consultants at large should be determined by the committee as a whole, after having received suggestions from all representatives.

The report should be the sum total of the opinions and views of each of the committee members. Each of the major issues should be discussed until consensus of committee opinion is achieved. The drafts of the report should be reviewed by all members of the committee and changes made until all are

satisfied with the results. Differences in opinion should be fervidly sought and recorded separately from the major body of the report.

On the whole there should be constant awareness on the part of the committee members of the mechanisms involved in group dynamics. A strong effort should be made to achieve a maximum level of interdependence. Continued self-evaluation in respect to the pitfalls of group processes is recommended. The report should address a section to this all important topic so that the reader at hand is aware of the mechanism by which the report was processed. It is in this manner that one is more clearly able to conceptualize the politics of health care.

Anatomy and Physiology of Committee Function

The Governor's Steering Committee on Social Problems met four times over a six month period prior to issuing its report. The first meeting was held on June 22, 1970 at the University Club in New York City. It was a short two hour luncheon originally intended to serve as a forum for discussion of the May 14-15 Governor's Conference. Only committee members were invited. No consultants or testifiers were present. The main issue of the day was to separate the committee members into two sub-groups (one financing, the other organization and delivery) to maximize the opportunity for group interaction. The only other action taken was to set a date

(August 20, 1970) for the first of three hearings.

Three of the four meetings (August 20, October 27, and December 21, 1970) were New York City based hearings at which testimony was taken from invited guests. Consultants and committee members were present at each of these. The purpose of these meetings was to provide the committee with its major health care input. There was little time for general discussion and at no time did the committee members meet formally to discuss the day's events or make decisions.

On one occasion (October 27) there was an informal supper meeting for committee members only. There was, however, no discussion of the day's testimony and no decision making. Instead, the committee heard about Victor Weingarten and Martin Cherkasky's visit to the U.S.S.R. They had made a one week excursion to study Russia's system of delivery of health services. Their main emphasis was on the Soviet's widespread use of physicians' assistants. They commented that the Soviets were phasing out this latter group at a time when the United States was just beginning to utilize them.

Two of the three hearings took place at the New York City offices of Xerox Corporation and one in the conference room at C.E.D. (Committee for Economic Development). The committee members sat along one side of a long rectangular mahogany conference room table, each in their own labeled places. The "core nucleus" (Weingarten and Wilson) sat at the center of the table surrounded by the other committee members. Those

testifying before the committee sat directly opposite the "core nucleus." The remainder of the table was filled by consultants and guests. Coffee, danish pastry, and elegant luncheons were provided in either the Xerox or C.E.D. dining rooms. A cocktail hour always preceded each of the luncheons.

The setting was designed to approximate a Congressional hearing. By this, it is meant that the committee sat and listened to testimony, occasionally asking questions, but hardly ever expressing opinions and never making decisions. Most of the committee members spent most of their time listening to others. All was quite organized. Meetings began on time and a considerable effort was made to keep to a preordained schedule. It was common to see secretaries and messenger girls running in with messages for either Director Weingarten, Chairman Wilson or other committee members or consultants.

The reader is probably somewhat interested in the personalities of the various committee members. Bibliographies of each appear in Appendix B.

Chairman Wilson was described in the first chapter as a forceful, convincing speaker who spoke with an incessant smile. Informally, he was a diplomat. He was always quite friendly, but continually active. If Wilson was active, Director Weingarten was hyperactive. He often found it difficult to sit in one spot without fidgeting or shaking. One received the impression that his energetic mind worked continuously.

Vice-Chairman Cook (Chairman of the Board, General Foods Corporation) could only be described as stately. He spoke slowly with a deep, rich and mellow voice. He was truly cool, calm and collected. Mr. Cook enjoyed conversing and often cited personal experiences and asked a lot of questions about everything.

A number of interesting comments may be made about a few of the remaining committee members. Robert Bernhard (Lehman Bros.), a personal friend of the Governor, was extremely quiet. He hardly spoke at all at the hearings. In private, however, he was quite enthusiastic on occasion. He would, for instance, get "red in the face" talking about the beating the college students received at the hands of Wall Street constructionmen. Harold Grey (Chairman, Pan American World Airways) was an extremely intelligent, sly character who very much enjoyed talking about some of his most rewarding personal experiences. His philosophy of life was at times a bit sarcastic. He, too, spoke very little at the hearings. The most publicly outspoken of the committee members were Philip Klutznick (Urban Investment and Development Corp.) and Harvey Russell (Vice President, Community Affairs, Pepsi Cola. Probably the most respected among the group was Baldwin Maull (Vice Chairman, Marine Midland Banks). "Baldy", as his friends called him, spoke relatively infrequently. When he did talk he did so with an almost devilish smile and always held a captive audience.

The composition of the committee certainly did not fulfill the criteria of the model presented earlier. Several members of the committee were close friends of the Governor. This was especially true of Joseph Wilson, Robert Bernhard, Baldwin Maull and Harvey Russell. Mr. Maull and Mr. Russell were both appointees to the New York Board of Social Welfare, the former of the two being chairman. Eight of the seventeen committee men were trustees of hospital board and one a late appointee was President of one of the country's major health insurers. The latter, Henry Smith, had on several occasions testified on behalf of the Health Insurance Association of America. This organization represented the major private insurance companies, which in fact, had their own proposal for a national health plan.

The committee largely represented the top managerial echelon of American busines. Of seventeen members, there was one minority group member (Mr. Russell), one student (myself) and one who dealt directly with consumer relations (Mr. Russell, again). The heavy leaning toward business interests was, of course, the supposed selling point of the committee. However, it was bound to have repercussions in the manner in which the group processed its input.

The committee functioned in a semi-autocratic manner with control in the grasp of a select minority. Victor Weingarten, Director of the Institute of Public Affairs and a brilliant organizer, largely worked with the chaiman, Joseph Wilson of Xerox, Vice-Chairman C. W. Cook of General

Foods, and possibly one or two other members. Together this group and, in some cases, Victor alone chartered the course of the committee. This is not meant to condemn the "core nucleus" (Weingarten and Wilson) as their control was, to a degree, a result of disinterest of committee members and preoccupation of the latter with involved and time consuming work schedules.

Nor is this to deny Mr. Weingarten credit for his managerial proficiency. His organization and planning of the Governor's Conference, the four committee meetings, the Washington trip and the final luncheon was superb. He traveled extensively collecting data for the committee, even embarking on a trip to the Soviet Union to examine their health care system. Victor, furthermore, personally interviewed all new committee members as well as consultants.

However, the committee suffered from this excessive patriarchy. Members were denied the privilege of choosing or approving the choice of consultants or those who testified. In fact, suggestions were occasionally suppressed. The Student American Medical Association was denied the opportunity to speak before the committee because scheduling was "booked".[1] There was only one meeting in which the committee members met alone. The development of group processes was stifled from the start and, furthermore, was effectively suppressed during the hearings as well (see later).

The choice of consultants (see Appendix for consultants) was obviously biased. Overall they were quite renowned, com-

petent, individuals. They represented the liberal, but not the radical; the conservative, but not the ultraconservative. You might say they would, with one or two exceptions, easily fit within one standard deviation of the mean of the political spectrum. Their philosophies, which we will examine in some detail, exalted the glories and benefits of pluralism and the private sector. A few consultants were notable by their absence. Rashi Fein, of Harvard, mentioned widely in the Business Week article, was not asked to participate. In a private interview, Victor Weingarten stated that he was not suitable because of his "irrationality".[2] There was no mention made of philosophical differences, but Dr. Fein had been quite critical of Governor Rockefeller's financing mechanisms in his universal health insurance proposals (see Chapter I). Quite clearly, the "core nucleus" (Weingarten and Wilson) wished to have an amiable group.

In additon, there was strong element of conflict of interest among the consultants as well as the committee members (see above). Martin Cherkasky, a strong influence, was simultaneously a member of the Committee for National Health Insurance (sponsor of the Kennedy bill). The most prestigious consultant, Wilbur Cohen, former Secretary of Health, Education and Welfare had written the Javits proposal and "had a hand" in the Kennedy and Rockefeller bills as well. Dan Pettengill of Aetna, a close friend of committee member J. Henry Smith, was chief sponsor of the proposal for universal coverage put

forth by the Health Insurance Association of America. Furthermore, Walter McNerney was both President of Blue Cross and Chairman of the Governmental Task Force on Medicaid and Related Problems.

Those testifying (see Appendix A) were, on the whole, a homogeneous group as well. Except for the A.M.A., representative Mel Glasser of the United Auto Workers (representing Leonard Woodcock) and a few representatives of group prepaid practice organizations, middle of the roaders predominated. Thus was a heavy preponderance of government sponsors and a remarkable deficiency of physicians and other health providers. This was despite Mr. Wilson's promise that all factions would be equally represented.[3] The committee's hearings were both provocative and stimulating, but, on the whole, lacked the zest produced by the conflict of strongly opposing interest. Without consciously realizing it, the "core nucleus" of the committee, had with few exceptions, chosen consultants who shared their common goal of maintaining the viability of private interests in the health care field. The few exceptions, like "lambs in a lion den", were consumed by the sheer magnitude of unanimity of opinion among committee members, consultants and testifiers. This as well as other aspects of the group as a whole will be emphasized as the specifics of the testimony are further developed.

Committee Input

While it might be interesting to provide a detailed summary of all that occurred at the hearings, it would be infeasible, impractical and counter-productive to the aims of this paper. Thus, the necessity of selection arises. The plan is to focus on the key issues, the highlights of the testimony with an eye focused on the genesis of the committee's final report.

One of the committee's primary concerns was group practice, specifically comprehensive pre-paid group practice (health maintenance organizations). The Fortune article devoted a whole section to the Kaiser Permanente plan. It is thus, not too surprising to discover that both the founder of Kaiser, Sidney Garfield and the Vice-President and Director of Medical Economics, Arthur Weissman both testified before the committee. Mr. Weingarten also arranged to have consultant Martin Cherkasky's good friends, Dr. George Melcher, President of HIP and Dr. Harold Wise of the progressive OEO Montefiore Hospital Neighborhood Medical Care Demonstration present their views.

The advantages of group practice, especially of the prepaid variety had been adequately stressed in Anne Somers' text (see Chapter II) "Paradox of Health Care" as well as in the workshop and plenary sessions at the Governor's Conference. In fact, the closing session had been dominated by Dr. Warter's

claim (see Chapter II) that a system such as Kaiser's could be extended to the entire population at a cost of $170 per capita. This was well below the $294 per capita figure based on the present $69 billion dollar health economy.

After a relatively brief introduction in which he highlighted the origins of Kaiser Permanente and praised its method of operation, Mr. Garfield revealed one of its basic defects. Removal of the fee-for-service, the traditional regulator of flow into the health care system had resulted in overutilization of the Kaiser system by a large proportion of what Mr. Garfield termed the "well" and the "worried well". He went on to describe the use of health testing (computerized history and multiphasic screening) as a new regulator of flow into the medical care delivery system.[4]

Dr. Garfield envisioned the application of this principle beyond the confines of Kaiser. He spoke of a central sick care center surrounded by four or five neighborhood health centers, staffed by physician assistants which would provide health testing services, a health care service (designed to keep people well), and a preventive maintenance service which would cover the routine treatment of high incidence chronic disease. This new supervised role for paramedicals was Dr. Garfield's answer to a severe manpower shortage, which despite commendable efforts, would not be correctable for decades. He recommended national application of his "health testing principle" prior to the institution of a national health insurance plan, and

like many to follow, stressed the dangers of instituting a national plan without first restructuring the organization and delivery of health services.

Dr. Garfield also stressed that it might not be feasible to extend the Kaiser model to the entire population.[5] Experience had shown that certain areas like New York were less receptive than the West Coast.[6] George Silver, replying to the latter supposition, implied that cultural and class patterns of use were often responsible for differing patterns of acceptance.

Probably the most community/consumer oriented aspect of the hearings revolved around Dr. Harold Wise's description of his OEO sponsored medical care program for the indigent of a fifty-five square block radius in the South Bronx. His program was described by Victor Weingarten as the most successful OEO program in the nation.[7] Dr. Wise introduced the concept of the health care team to the committee. His program had effectively demonstrated the feasibility of going into the community and generating health care needs. It also stressed the benefits of attending to the health of an entire family and the value of emphasizing the need for continuity, rehabilitation and most of all prevention.

Overall the committee extracted two basic tenets from Dr. Wise. The first, was that any approach to the problems of the poor must be universal in character. You could not address the problems of health care without recognizing the

social pathology of the poor: their needs for housing, education, employment, and recreation. Second, in contradistinction to Dr. Garfield's views, the physician needed to become personally involved in the care he administers so that he would be able to recognize the importance of the patient as opposed to the pathology of his disease.

George Melcher's relation to group pre-paid practice was clearly managerial. He convinced the committee that a private health concern could successfully dictate demands for quality and efficiency to the provider population without repercussion. He demonstrated that the most streamlined and effective techniques of cost control and automation could be successfully applied to the health care industry. He also described how a private concern like HIP, by ingenious demonstration, could influence the passage of politically progressive health legislation. His one non-managerial "pearl" was that despite the best possible management techniques, the committee would have to address itself to the moral issue of priorities in health care spending.

Dr. Melcher was talking baseball to umpires and he knew it. He went out of his way to promote himself as "Mr. Tough" toward organized medicine;

> Remember I had my first battle with organized medicine. The Executive Secretary of the Society told me, "If the doctor says he performed a gastrectomy in his office, we believe." I closed my papers and said, "Fine, fellows, I am leaving." And he was the first person we turned over to the professional conduct division of the Board

of Regents.[8]

And the businessmen "ate it up".

The remainder of the testimony derived from sponsors of various philosphies of financing medical care. They were among the most prominent of their kind. Their fund of knowledge often seemed unlimited and traversed all of the interrelated medical care areas. To be considered first were those sponsors of plans and accompanying philosophies which were other than mid-spectrum.

Dr. Russell Roth of the American Medical Association, as suggested earlier, should have brought a target with him when he came to testify. His assignment was to talk about the A.M.A.'s Medicredit which several of the consultants had condemmed in earlier talks. Wilbur Cohen referred to the plan as "pluralism run rampant" - a gift of twelve to fifteen billion in public funds to private insurance companies without strings.[9] He agreed with Rashi Fein who had proposed a similar plan for the express purpose of insuring Federal takeover of the health care system. In contradistinction, Dr. Roth referred to Medicredit as:

> A very progmatic and practical approach which is based on a growing conviction that we want to avoid insofar as possible further over-performance....and also it is our conviction that it is better to build on the accomplishments, the good things of medicine from the past.[10]

For those who could ignore the Medicredit proposal, Dr. Roth had some commendable thoughts. He stressed the need for a multi-faceted approach to the multi-faceted problems of health care stating it would be naive to believe that any one plan could direct itself to all the complexities of existing problems. This was essentially the view of consultants Somers[11] and Cohen.[12] Dr. Roth also made it clear that statistics were not often true indicators of the fact. In effect it was to the interest of some to make the health crisis seem worse than it really was.

The Committee of One Hundred was represented by Mel Glasser, who was pinch hitting for Leonard Woodcock. The latter was, at the time, negotiating a labor settlement with General Motors. Mr. Woodcock's predecessor, Walter Reuther, had been invited to the May 14 conference before his untimely demise. The Glasser presentation afforded much greater opportunity for meaningful interaction than did Roth's, because the issue was what kind of change and what rate of change as opposed to the need to change at all.

Mr. Glasser spent much of his allotted time talking about the Kennedy bill or Health Security program (see Appendix D). Much of Glasser's philosophy was based on the promise that the country was going to have a national health insurance plan within the next few years. With this assumption in mind, the Committee of One Hundred went on to couple a total reorganization of medical care with broad-based financing. It is to be remembered that Wilbur Cohen,

commenting on group practice (see earlier), had stated that changes of great magnitude (and he referred directly to the Kennedy bill) would take some time to implement - that it was foolish to think that with the resistance to change that existed in a pluralistic society such as ours, a radical program could be enacted in a single sweeping piece of legislation.[13] Consultant McNerney of Blue Cross had also stated the same concept. This was clearly a major issue and probably one of the two primary reasons the consultants and, hence the committee, were against the Health Security Program.

The second issue was one of Federal versus private organization and control. Those present, as stressed earlier, mostly favored maintaining the viability of private interests in the health care field. Walter McNerney[14] and Anne Somers[15] both shared the view that large government programs with broad-based financing were usually keyed to the least common denominator and offered less flexibility than public-private interplay. In addition, Mr. McNerney emphasized what Governor Rockefeller had repeatedly stated - (see Chapters I and II) that when money goes through one source and that is largely political, health often has a lower priority than other issues and is undervalued.[16] These two joined George Silver[17] and Wilbur Cohen in calling for a system based on the pluralism of public-private interplay. Wilbur Cohen believed the Federal government couldn't handle the administration of a program for two hundred million people.[18] Mrs. Somers, supporting private rather than public financing, left enough flexi-

bility in her FEP proposal to allow for Federal takeover in the event of a private sector failure.

To the contrary, Mel Glasser believed the private sector was totally incapable of handling the problem. He cited their 1.7 billion dollar administrative costs and claimed that 1.1 billion of this amount would have been saved by a Federal approach. He then argued with Walter McNerney's charge that Federal programs were not innovaters: "That it is only programs of size in this complex society that in effect get innovative."[19]

Consultant George Silver jumped in at this point and warned of the dangers inherent in in-fighting among allies struggling for a common cause, that being to change the system. With the fragmentation of programs in DHEW and the multiplicity of congressional committees dealing with isolated segments of the medical care dilemma, Dr. Silver envisioned a process in which political jockeying would result in a program which, by nature of its specifics, would be totally unacceptable to the people who were actively fostering change.[20] He wanted to know:

> What are the irreducible means we have to insist upon before we want a change in the present inadequate system? In other words, can we get a level that we are going to live with that we will know a little more about before we exchange for this present level that we cannot seem to live with at the present time?[21]

The remainder of those present had more in common that they themselves believed possible. Chairman Wilson stated

this view at the conclusion of the second hearing:

> It has been an extraordinary day, full of contrast....And the areas of agreement are beginning to emerge here from places where we never thought there would be agreement and it is fantastic.[22]

Several of those present believed, as exemplified by Anne Somers' theories, that the hospital was the logical future focus of an expanded community health services system. In addition to Mrs. Somers, two of the country's most progressive hospital administrators, John Knowles and Martin Cherkasky were present in addition to George Grahm, the immediate past President of the American Hospital Association.

Mrs. Somers' emphasis at the hearings was identical to her chief concerns at the May 14 conference: the organization of community health services and the generation of an adequate financing proposal for a national health insurance scheme. The former was amplified in a revised version at the August 20th meeting.

The August 20th revision reiterated the need for the hospital to be the organizational catalyst, the referral center and professional monitor of quantity and quality of care administered throughout the entire community. It would be both the primary operational center for community health services and the primary center for comprehensive health

planning at the community level. Mrs. Somers clarified her thinking by describing the operation of Mercy and University Hospitals, two theoretical models.[23]

As mentioned previously, George Grahm read his text to the committee. Its presentation was rather boring. He called for a "restructuring" of the hospitals functions by expansion of planning and non-regulatory governmental controls.[24] He went on to reiterate many of Mrs. Somers views concluding that the hospital was "the logical place through which we must meet the future needs of all the people".[25] Much like the summer re-runs, Dr. Grahm's speech was invigorating, but somehow it was not the same the second time around. Dr. Grahm made mention of the American Hospital Association Ameriplan, but details were not available for discussion. A summary of this plan appears in Appendix D.

John Knowles, "Robin Hood" of hospital administrators would have scared the A.M.A. with his vocabulary alone. He referred to state bureaucrats as fuzzy-wuzzies,[26] and hospital administrators as lower Slobovian characters with a turnover rate more rapid than college deans.[27] His role was to explain to the committee how difficult it was, in Anne Somers' words to get from "here to there". In doing so, he reiterated a number of his most startling failures as director of Massachusetts General Hospital.

His most valuable contribution was his statement of a number of medical care realities. After stating his belief

in institutional self-determination and autonomy, he recommended that the only way to rationalize the hospital's role as the logical center of the medical care system was by legislative mandate.[28] Most administrators were useless, hospital trustee ignorant status symbols, and doctors, not "bastards" but "like the rest of us" in their taking maximal advantage of the diffuse management base of the hospital.[29] Doctors placed on hospital boards insured judgment in favor of the expert. Community needs were totally ignored.[30]

Dr. Martin Cherkasky, progressive director of Montefiere Hospital, member of the Committee of One Hundred, and sponsor of Dr. Harold Wise was a forceful speaker with a booming voice and iron-clad convictions. He was verbose and opinionated as well. Cherkasky was, however, genuinely concerned with the needs of the poor. He stressed that most medical care administered, despite its scientific merits, was often lacking in human concern and passion: He claimed:

> These circumstances do a serious disservice to the medical students, interns, and residents who became accustomed to seeing people dealt with in very undesirable and damaging ways.[31]

He had openly clashed with the Governor on the issue of community involvement by stating:

> The hallmark of a democratic society is that the people control the social institutions that serve them. We must recognize such communal

> involvement not as a concession, but as a long denied right and we must not hurry away when the going gets tough.[32]

For all his efforts, discussion of community participation and community control at the conference was negligible. The issue was mentioned a few times, but never debated.

George Silver, of the Urban Coalition, had already been noted for his paper at the May 14th conference (see Chapter II), and for his quick sense of humor. He had, at Victor Weingarten's request, elaborated, in full, his claim that existing legislation could be redirected to release funds for progressive change in the health care field. Those present were quite receptive to his pleas for grant simplification and consolidation, co-ordination of funding, and direction of federal funds at single versus multiple causes.[33]

George Silver's main contributions were to make meaningful comments, and, more important, to ask meaningful questions on key issues. His role, was comparable to that of practical "nuts and bolts" modern-day Socrates. This function was alluded to earlier when Dr. Silver interrupted the feuding between McNerney and Glasser to warn of the consequences of avoiding a united front. In the discussion following Harold Wise's talk, he stressed the need for a universal approach to the problems of the poor and urged a sophisticated analysis of the successes and failures of social functioning in the past ten years to determine future directions and needs.[34]

The remainder of the testimony was largely concerned with the financing of health care. It was obvious that this topic received greater attention than other aspects of the medical care "crisis". The December 21 hearings were devoted to nothing else. The most reknown experts in the field testified and debated the complex and, in Wilbur Cohen's view,[35] unsolvable problems of financing for an entire day. The existence of more than ten different approaches embodied at least ten different plans bespoke of the difficulties encountered.

Once again, the committee relied upon Anne Somers to present a model for effective financing. She was quite humble for all the attention she was receiving. Mrs. Somers saw the current challenge in financing as a necessity to devise reforms which:

> will correct the shortcomings of the existing financial pluralism (its waste, extravagance and unmet needs), but retain the obvious strengths, while adding the degree of public regulation and public accountability necessary to keep the pluralistic system from destroying itself.[36]

She proposed a two-phase program which consisted of a set of immediate reforms to meet urgent human needs and strengthen present financing mechanisms and a long range set of well defined but flexible goals to meet needs over the next twenty to thirty years. The two phases were to be considered irreconciable parts of a single evolving process.

The only reason for two phases was that, as discussed in Mr. Glasser's presentation, the middle of the road people felt it was impossible to accomplish everything at once. It involved George Silver's conception of a fixed rate of innovation.

Her immediate reforms were highlighted by 1) a series of federal standards for private health insurance including federal licensing of carriers; 2) DHEW grant and loan support of pre-paid group practice; and 3) immediate efforts to strengthen Medicaid followed by eventual incorporation of the latter into a national health plan. For Phase II, Mrs. Somers defined nine basic principles which are listed as she presented them:

- Universal coverage of the resident civilian population without distinction as to income or contribution.
- Comprehensive benefits defined as something in the order of seventy-five percent of coverage of family care expenditure.
- Competitive underwriting by a limited number of private carriers.
- Consumer free choice of carriers, providers and provider systems on a meaningful informed basis.
- Adequate and stable income for providers.
- Incentives for economy and efficiency.
- Equitable financing.
- Administrative simplicity.
- Acceptability to the majority of providers and consumers.[37]

There would be a core federal program competing against the limited number of private carriers. The former would provide coverage for any finding it difficult to obtain private coverage.

The Somers' plan incorporated a number of features of current national plans. There was the core Medicare program (Javits), universal one-class coverage (Kennedy, Griffiths), small patient co-payments (Griffiths), federal standards for private insurance (Health Insurance Association of America), and the central thesis of the Federal Employees Benefit Plan (FEP), which Mrs. Somers believed to be "one of the best and least appreciated programs in the country".[38]

Mrs. Somers' plan formed the nidus for a board discussion of financing at the December 21 hearings. Mr. Arthur Weissman of Kaiser cautioned that progress toward a national plan might be slower than expected and questioned whether the adoption of national minimum standards earlier rather than later would be helpful.[39] He also commented that in a two step approach to national health insurance what occurred in the first step might considerably alter even the goals for the second.[40]

Mr. Weissman was very much concerned with the role of the provider in any future system. He did not feel that providers would be satisfied under any kind of universal plan.[41] Weissman urged a pluralistic approach, expressing a fatalistic attitude about increasing controls and great fear of broad based change such as that inherent in the

Kennedy legislation.

Howard Newman, Director of Medicaid, had the unhappy chore of defending his program. He pointed out several of Medicaid's pluses including its exposure of deficiencies in the health delivery system and its innovative influence with respect to health maintenance organizations. Newman viewed federalization of the program as a simplistic measure claiming that Medicaid had identified rather than caused the problems awaiting solution.[42] His main plea was for the ingenious use of federal leverage to effect reform and restructuring of the present health care system.[43] He questioned how much leverage the government would have to exert to provide basic coverage for the indigent and the population not receiving adequate care from other sources.[44]

Mr. Arthur Hess, deputy commissioner of the Social Security Administration pushed for "deliberate gradual reform with constant pressure applied at important points."[45] It was his view that it was ridiculous to expect public programs to provide incentives for pre-paid group practice and cost-effectiveness by institutional providers without using federal leverage to redirect the vast private expenditures toward the same goal. Together, the two would constitute "public clout".[46] In fact, one could go even further by encouraging private enterprise to provide capital expenditures and front-end money at points of leverage (i.e. the establishment of pre-paid group practices). Universal federal coverage, in his opinion, was not to be attempted until

"maximum federal leverage had been applied to existing programs".[47]

Like George Melcher, he called for public consideration of euthanasia stating that the latter was inevitable in the face of ever-increasing federal controls. His comment, as might be expected, engendered a strong emotional reaction.

Committee member Phil Klutznick stated "We cannot set ourselves up as being God. We have got enough trouble being man."[48] McNerney commented that this type of decision was best left to private transaction. He also wisely commented that upon analysis (no matter who was doing the analyzing) the decision at hand was "a matter of preference and value rather than fact".[49] In any case, committee member J. Henry Smith reminded those present that the savings involved in this delicate issue were considerably less than, for instance, the extra day's stay in the hospital.

Walter McNerney and Daniel Pettengill played quite significant roles at the hearings. The two of them were present at two of three hearings. Both were quite verbal. Both held the undivided attention of the committeemen, and both were excellent promoters of the kind of private enterprise philosophy inherently popular with the "core nucleus". The private insurance carriers were well represented.

Dan Pettengill of Aetna, representative of the Health Insurance Association of America,was cool, calm, rational and extremely convincing. His most valuable contribution

was the practicality of his suggestions. He had a well respected knack for picking out key faults in proposals and suggestions. For example, Anne Somers' plan involving private insurance company competition with a core Medicare program was doomed because the government program would, in the end, offer more services for less money. Similarly, federal licensure of carriers would not work because it violated state's rights.

McNerney's ideas had a strong influence on the "core nucleus". They were extremely rational and tended to involve systems rather than specifics. To promote greater social justice and efficiency, McNerney stressed the need for a unified view of health encompassing all of the sophisticated challenges of the health care system. He criticized Anne Somers for omitting the need for flexibility in her criteria for a national health program. Ideas and innovations were to be allowed to flow up from the grass roots as well as downward from a self-serving health establishment preoccupied with internal professional needs. McNerney called upon the committee to consider what he called "trade offs": the relative priority of health services (versus education, nutrition, housing, etc.) in the determination of health. In recommending total reorganization of DHEW, based on principles of corporate management, he stressed the need for a department which would establish goals and priorities rather than frantically attempting to meet imposed Congressional deadlines.

George Silver referred to Wilbur Cohen as "the greatest living expert on legislative language and authorship as well as the political nitty-gritty of the health field".[50] To the committee he was that and more. His image was that of "the professor". He spoke slowly, clearly and methodically. His appearance resembled that of an endearing Mr. Chips. Dr. Cohen, a short, plump gentleman carried a tattered, shoddy briefcase which added a certain warmth to his omnipotent character.

Professor Cohen stressed the realities of "real politik" - those factors and forces the committee would have to take cognizance of in making suggestions for change. The problems in our fragmented "non-system" of medical care were fundamentally insoluble - there would be no significant solution to most of our problems in this decade.[51] To make matters worse, no matter what plan was finally implemented, costs would continue to rise precipitously. In Wilbur Cohen's words "If you can keep it (the rise in medical care costs) to twice as much (as the general cost of living index) during the next ten years you will be doing damn well".[52] In fact the demand for medical services was so great that utilization could be expected to increase dramatically as well.

The reaction of society to the above prediction would be the imposition of greater and greater controls on the practice of medicine. Dr. Cohen questioned the legality of this presumed fail accompli. It was an extremely difficult question why certain groups in the free enterprise system should be the ones to take controls. Cohen cautioned there

were a large number of patients, taxpayers, and legislators who were not enamored by proposed innovations such as group practice or pre-payment.[53] This lack of urgency meant that whatever plan was chosen would have to be "phased in" quite gradually. As suggested by others, the instant immediate solution would not be tolerated.[54] Wilbur Cohen had great doubts that the government, and especially DHEW, could administrate a program of universal insurance for the entire population.[55]

Despite the resistance cited, Wilbur Cohen envisioned a greater willingness to change the system now, or at least in the next few years, than ever before. Any plan should have as its goal the institution of the "least worst" system because, as cited above, there were no perfect solutions. Even so, Medicaid would have to be retained, improved, and strengthened to care for the leftover expenses, especially extended long-term care.[56] Cohen pointed to the necessity of offering a limited scope of services, limited consumer free choice, and using federal funds to exert leverage on existing programs.

Professor Cohen remarked that the poor would have greater accessibility to health services if Garfield's multiphasic screening regulator was coupled with a vastly expanded system of group practices (i.e., O.E.O. neighborhood health centers).[57] He liked Anne Somers' concept of competition among a limited number of controlled carriers and expressed the opinion that the payroll tax was far superior to the monthly

flat fee because individuals were not required to chip-in while sick, unemployed, disabled, or retired.[58]

In respect to a new system, Dr. Cohen favored a plan consisting of at least two to five sequential steps in which the administrators would be given advance warning of enacted changes. He stressed the desirability of minimizing administrative aspects and including the commercial carriers in some sort of new arrangement.[59] He predicted the inevitability of a Mills' bill and the probability that we were now progressing through a stage of idea germination. In the future there would be revision of current thinking and the probable final emergence of the unexpected.[60] He cautioned the committee to wait until the administration had promulgated its ideas before committing themselves.

Despite its relative homogeneity, the testimony received was superb, representing the most pragmatic, most intelligent minds in the medical care field. It, on the whole, was the voice of experience. A consensus was achieved on many issues by virtue of the number of times the same opinions were repeated. The need for federal leverage, selective intervention - whatever you wish to call it - was paramount. A multifaceted approach was dictated by their mutual respect for the virtues of a pluralistic society. Domination by a monolithic, centralized superstructure would reduce flexibility and increase the opportunity for political intervention.

The need for a managerial input, so stressed at the

opening conference, resulted in a general plea for federal reorganization, simplification and consolidation at both the Congressional and Cabinet levels. There was need for a national council of health advisors and for the infusion of corporate structure into the Department of Health, Education, and Welfare. Hospitals were to follow George Melcher's lead, and incorporate all of the latest managerial mechanisms for cost efficiency. Even so, the savings were to be found in the reduced hospitalization and surgery offered by group pre-payment.

Costs were on the increase no matter what the solution. Control and more controls were on the way as was increasing provider unrest and protest. The question of the legality of infringing on the basic rights of the physician augured for sound judicial review. The trilegy of increased resources, increased utilization and sky rocketing finances would inevitably lead to a consideration of "social controls".

A definitive solution to the multitudinous problems was not at hand in the next decade. The most meaningful approach would be the exertion of constant gradual pressure to change with an ultimate goal of producing the least worst system. A number of well planned and elucidated phases or steps would be necessary to insure minimal disruption of an already tenuous health economy. Overall, the most profitable innovation possible would be the assurance of maximum flexibility coupled with the meaningful input of the educated and enlightened consumer. The challenge was to make health a

meaningful goal for each and every American realizing that health and health services were only distant relatives.

Committee Interaction

The philosophical and analytical contribution of the committee members to the hearings was, on the whole, quite limited. The committee accounted for less than one percent of the "pages occupied" at the hearings. Although they made between thirty-six and fifty-one percent of the comments, the numbers were drastically reduced when the chairmanship function was considered. In any case, the majority of the committee's contribution was tracable to the chairman, Mr. Wilson, the vice-chairman Mr. Cook, committee member Klutznick and proponent of the private insurers, J. Henry Smith.

Chairman Wilson, of the eighty times he spoke, made only one definitive statement, that being his support for federal controls. At one point he pitted Walter McNerney against Mel Glasser by asking McNerney to restate his feelings concerning gradual versus sudden institution of major change. In another instance, he requested Mr. Pettengill to explain, in view of the extensive restrictions placed on the commercial carriers, how the insurance companies were going to foster the necessary organizational changes and promotion of resources.

Mr. Cook had less difficulty interacting with those who testified. He frequently cited the experiences of his own

company (General Foods) in an attempt to see how they compared with realities in the health care field. For instance, the problem in General Foods seemed to be a reluctance of employees to see the physician rather than the ever-willingness Dr. Garfield had described. He commented that General Foods economized by only requiring the aging and the unhealthy to have yearly or six-month check-ups, and that some of the younger folk were only examined on a three year basis. He also questioned whether physicians were ever rewarded for quality performance by merit increases.

Mr. Cook had a tendency to clarify questions by other members of the committee as well as attempting to simplify consultants' or testifers' comments. An adaptation of the latter was his proclivity to ask for definitions.[61, 62] These are both qualities which may be attributed to the function of the chairmanship but which Mr. Wilson failed to exhibit. Mr. Cook even made a wisecrack on one occasion. The consultants were discussing the sometimes enormous costs of long term maintenance. Cook blurted out "you will have to shoot them then".[63] He generally was quite courteous to testifiers except in the case of the A.M.A.'s Dr. Roth (see Chapter IV).

A number of Cook's questions were excellent. He asked Dr. Wise if he would make any changes if he had to restart his South Bronx experience, and also questioned whether the difficulties he was having with his health care team were due to the newness and uncertainty of the operation (likening

it to Porter's Ship of Fools). At one point his own naivete' concerning medical care matters was uncovered. He likened preventive care to a defective elevator stating that considerable savings could be achieved if the elevator was repaired earlier rather than later. Dr. Cherkasky enlightened Mr. Cook by explaining that in most instances the patient, no matter how intelligent or how educated, had no way of gauging the quality or necessity of the care he received and thus, often, was not even aware that he needed help until the pathology of the disease process was far advanced.

By far the most meaningful contribution by any committee member was that of Philip Klutznick, Chairman of the Board of the Urban Investment Company. He, more than the others, talked to the issues as opposed to peripheral and often unrelated topics. He frequently referred to his experience in establishing a national housing policy in 1949. He talked for nine pages (three meetings) versus a total of nine pages for all other committee members excepting Mr. Smith. He was the only member of the committee to make commitments stating his and the Steering Committee's dedication to maintaining the viability of private enterprise.[64] He commented, as well, on his belief that the Kennedy and Griffith bills were ploys to obtain a more moderate solution to the problems of health care.[65]

He was quite free in expressing himself and believed strongly in the interaction of all social issues.[66] Klutznick stressed the importance of flexibility stating that the

two-to five-percent allotment of funds by Committee for National Health Insurance for adjustments was legitimate. One had to improve, adjust, and be prepared to react to emergent situations, especially in geographically remote areas.[67]

Mr. Klutznick was most interested, as mentioned above, in maintaining a public-private intermix in health matters. It would do no good at all to swing to extremes. He claimed it was impossible to separate the contribution of the private sector from the public forum.[68] He referred to the national housing policy established in 1949 which accomplished nothing until private resources were tapped by direct federal subsidies. Klutznick was concerned about the large (1.3 to 1.7 billion) administrative expenses of the private carriers. He openly questioned what the comparable figure would be for the federal government. He also felt that federal licensing of carriers, as suggested by Anne Somers, or physicians was not feasible because of the reality of state's rights. Instead, he suggested revenue sharing with "strings attached" as a more politically realistic substitute.

In any case Klutznick reasoned that it was extremely unrealistic to expect, as Dan Pettengill had, that the governement would yield funds without controls.[69] Like Dr. Cohen, he believed in the ultimate failure, what he called political impracticality, of certain plans regardless of whether or not they had standards. There were those incalculable factors and forces which, despite well motivated

human efforts, were never considered.[70]

Mr. Smith of Equitable Life Insurance Company well represented the private carriers. Over twenty-five percent of his comments at the December 21 meeting were in support or defense of the H.I.A.A. proposal. He mentioned that H.I.A.A. covered the marginally indigent as well as the indigent, that there was no discrimination, and that private companies were going to accept the risk of being controlled so that they could become part of a program the country needs. Mr. Smith argued against an expanded Medicare as the core program in Anne Somers' proposal in much the same manner as Dan Pettengill.[71] He also stressed that the private companies had attempted marketing ambulatory coverage, albeit unsuccessfully.

The remainder of committee participation was fragmented, diffuse, and versed in the form of questions rather than definitive statements. Mr. Neal asked several point-of-information questions during the first conference. Mr. Grey's (Former Chairman, Pan American World Airlines) most poignant question was directed at the deficit in home care and other alternative forms of nursing. I brought up the issues of the irrelevancy of medical education, the question of continuity of care and the controversial issue of social controls.

The most valuable contribution among committee members was made by Mr. Klutznick. He was the only one to speak to the key issues, to express his and the committees candid

opinions, and to interact with the consultants and those testifying. The remainder of responses were either related to the chairmanship function or were most often peripheral to the central issues at hand.

The Governor had appointed the Steering Committee on Social Problems to promote state and national health reform and to engender improved relations with the Nixon administration. The committee was to transform the guidelines of the May 14 conference into a series of politically feasible recommendations. The Governor's Conference had placed strong emphasis on the gradual institution of a national health system preceded by a complete restructuring of the present health system. The latter was to rely heavily on cost-savers such as group pre-paid practice and the efficiency and economic incentives inherent in modern business management techniques.

The Steering Committee, dominated by a semi-autocratic "core nucleus" (see Chapter IV) had little difficulty in structuring their operation in such a way as to insure adherence to Conference guidelines. Weingarten and Wilson chose the consultants, those testifying, the meeting dates, and carefully planned the agenda of each get-together.

At no time prior to the drafting of the report did Steering Committee members meet formally among themselves to reveal or discuss their opinions. Their contribution at the three "hearings" had been negligible with the one exception of Mr. Klutznick.

It is thus not surprising that the gestault of the hearings (as summarized on page 102) was totally consistent with the guidelines set forth by Conference workshops guided and influenced by the Governor's attendance. The hearings were an impressive production, staffed by a superb cast and, yet destined to produce a pre-determined product. The latter was the result of a carefully planned structure and organization and lack of effective participation by committee members. The Conference and committee meetings were a publicity stunt to advance the Governor's personal motives. Enormous preparation, expense, and investment of personal creativity were required to create the front of independent action so essential to the American political process.

CHAPTER IV

FUNCTIONING OF THE STEERING COMMITTEE II GROUP BEHAVIOR AND GROUP PROCESSES

This is the second of two chapters dealing with the functioning of the Governor's Steering Committee on Social Problems. The examination of committee functioning by means of group behavior and group dynamics will enable us to determine the degree of independence of committee action and thought. Was the committee truly independent? If not, how much was it influenced by the Governor?; by its consultants?; by other factors? By studying group psychology in terms of the Governor's Committee, we will be able to learn more about the prototype of the politically oriented lobby. Who makes the decisions? How are decisions made? What are the factors which influence those making key choices? What purpose, if any, do such committees serve?

Group Behavior

The accompanying tables reveal three items for each committee meeting at which testimony was given and consultants present; 1) number of times participating; 2) pages occupied;

TABLE 1

Committee Member Participation

(* Chairman) Name	Bernhard	*Cook	Cunningham	Dallas	Gray	Klein	*Klutznick	Larry	Levy	Maull	Neall	Owens	Russell	Silberman	Smith	*Wilson	Weingarten	Subtotal	% Total per Date
Times Participated																			
8/20/70	0	52	1	1	4	4	9	—	—	—	4	1	11	1	—	29	2	117	36.0
10/27/70	0	19	—	—	10	8	5	0	—	0	2	—	0	—	1	25	2	72	51.0
12/21/70	0	—	—	—	0	6	54	0	3	2	2	—	—	1	31	26	5	129	45.0
Pages Occupied																			
8/20/70	0	0	0	0	0	0	0	—	—	—	0	0	0	0	—	0	0	0	0
10/27/70	0	0	—	—	0	0	6	0	—	0	0	—	0	—	0	2	0	8	5.2
12/21/70	0	—	—	—	0	1	3	0	0	0	0	—	—	0	0	0	0	4	5.2
Conversations																			
8/20/70	0	35	1	1	3	4	9	—	—	—	3	1	7	1	—	20	2	84	35.3
10/27/70	0	14	—	—	7	8	5	0	—	0	2	—	0	—	1	22	2	51	36.4
12/21/70	0	—	—	—	0	5	36	0	1	2	2	—	—	1	25	19	4	94	40.1

TABLE 2

Meaningful Comment Ratio

	8/20/70	10/27/70	12/21/70
Wilson	30.8/100	12.5/100	4.6/100
Cook	62.5/100	19.4/100	—
Klutznick	—	—	64.5/100

TABLE 3

Consultant and Guest Participation

Name	Cherkask	Cohen	McInerney	Pettingill	Silver	Somers	Subtotal	% Total per Date	Guests	% Total per Date
Times Participated										
8/20/70	28	16	—	—	26	10	80	26.0	18	5.5
10/27/70	11	—	12	7	7	10	47	33.0	2	1.4
12/21/70	—	34	33	15	—	27	109	48.0	7	2.8
Pages Occupied										
8/20/70	6	34	—	—	16	34	90	57.3	0	0
10/27/70	4	—	20	16	3	2	45	29.8	0	0
12/21/70	—	15	9	11	—	27	48	62.0	1	1.2
Conversations										
8/20/70	26	15	—	—	22	9	72	30.4	17	7.1
10/27/70	10	—	12	6	6	9	43	30.7	2	1.3
12/21/70	—	26	29	11	—	25	91	39.1	7	2.9

TABLE 4

Participation of Testifiers

Name	Garfield	Glasser	Graham	Hess	Knowles	Melcher	Newman	Roth	Weissman	Wise	Subtotal	Per-cent of Grand Total
Times Participated												
8/20/70	46	-	-	-	23	-	-	-	-	42	111	33.0
10/27/70	-	10	15	-	-	17	-	18	-	-	60	43.0
12/21/70	-	-	-	14	-	-	12	-	17	-	43	11.0
Pages Occupied												
8/20/70	18	-	-	-	29	-	-	-	-	20	67	42.6
10/27/70	-	23	26	-	-	25	-	24	-	-	98	64.9
12/21/70	-	-	-	10	-	-	6	-	8	-	24	31.1
Conversations												
8/20/70	23	-	-	-	15	-	-	-	-	26	64	27.0
10/27/70	-	10	11	-	-	12	-	11	-	-	44	31.3
12/21/70	-	-	-	14	-	-	11	-	17	-	42	17.9

TABLE 5

Maximal Individual Participation for All Meetings

Per-cent Time Participated	10.8	10.3	4.8	12.1	5.9	7.6	6.7	3.3	5.0	7.1
Per-cent Pages Occupied	0	2.3	0	0.5	2.5	12.7	7.5	7.0	4.9	16.3
Meetings Attended	2	3	1	3	2	2	2	2	2	3
	Cook	Klutznick	Smith	Wilson	Cherkasky	Cohen	McNerney	Pettingill	Silver	Somers

TABLE 6

Conversation:Participation Ratio (expressed in per-cent)

C/P

	8/20/70	10/27/70	12/21/70
Committee Members	71.7	70.8	72.8
Consultants	90.0	91.9	83.4
Testifiers	57.6	73.3	97.6

and 3) number of conferences participating. The first refers to the number of times a person commanded the attention of the group. The third item appears similar to the first but differs in that it defines the number of different conversations an individual took part in. For instance, if Mr. Smith made a reply, was answered, and then made one or two more replies to the answer, this was counted as one conversation and two or three participations. The second category "pages occupied" was designed to measure in units of "pages" (vs. time) the length of time an individual occupied the floor. The unit of time is pages and thus assumes people talk at the same rate. It is a rough estimate, indeed, but helpful when comparing the different participants.

Certain individuals on the committee never had the chance to participate because they failed to attend. The attendance rate hovered about sixty-nine percent for the meetings, but only thirty-seven percent of committee members made all three meetings. No one missed the entire set.

There were a group of committeemen who participated very little, if at all. This category was quite significant in that it compromised thirty-seven percent of the committee. The attendance record of this group was lower than that of the committee as a whole - 55% vs. 69%. Two of the members, Mr. Larry and Mr. Bernhard never said a word and two others, Mr. Cunningham and Mr. Dallas only spoke once.

The committee, as a whole, accounted for thirty-six percent (August 20) and fifty-one percent (October 27), of the

comments made at the conference (see accompanying tables). A significant amount of the latter was attributable to the chairmanship which was shared among three individuals. If these individuals are subtracted from the totals, the new range is 8.3-16.3 percent as compared with 26-48 percent for the consultants and 11-43 percent those testifying. The only committee to make more than ten comments per meeting was J. Henry Smith whose thirty-one introjections exceeded even Chairman Wilson's level. The reader is reminded that Mr. Smith, as President of Equitable Life Insurance and representative of the Health Insurance Association of America, had a good measure of professional interest in the issue at hand.

Three committee members served as chairmen at one time or another during the three hearings (August 20, October 27, and December 21, 1970). They were Chairman of the Committee, Joseph Wilson; Vice-Chairman of the Committee, C. W. Cook (General Foods); and Phil Klutznick (Chairman, Urban Investment and Development). The chairman differed in their approaches. Table II shows Mr. Wilson's meaningful comment ratio for three times as chairman to be 17.2/100. Meaningful comments refer to responses which are primarily related to the discussion at hand and not to procedure. Vice-Chairman Cook was better in this regard. His total for two "cracks" at the chair was 49/100, the first occasion being 62.5/100. By far the most involved of the chairmen was Mr. Klutznick, who responded meaningfully in 64.5/100 oppor-

tunities. Whether or not it is a virtue to talk from the chair is debatable. Excessive participating with a limited time schedule from the chair is an autocratic characteristic in that it prohibits others from giving their views by impeding the flow of discussion.

On the whole, it is apparent that one can generalize and state that the consultants and those testifying dominated the discussion. They made fifty-nine percent of the comments August 20, seventy-six percent October 27, and fifty-nine percent December 21. This fact is even more striking when you cite the pages occupied by these groups. They filled up 157 pages (99.9% of the pages filled by one person) August 20 versus none for the committeemen; 143 pages (94.7%) October 27 and 72 pages (93.1%) December 21. Except for the October 27 meeting where chairman Wilson ran a "tight ship", the consultants even outtalked those asked to testify. They occupied twice as many pages in the December 21 meeting. In addition, even though those testifying made significantly more comments than the consultants in both the August and October meetings they were outtalked forty-eight percent--eleven percent (over four times) in the December 21 meeting. The domination of this December 21st meeting by the consultants is significant since this was the meeting in which major policy decisions were formulated.

The next topic is the evaluation of the conversation to participation ratios (see Table VI). This ratio injects more meaning into those statistics which show the number of

times an individual "participated". Remember, a conversation is defined as a related series of replies and may imply more meaningful interactions. The lower the C/P ratio the more intricate and perhaps meaningful interactions a group or an individual had. The most uniform group, composition wise, is the committeemen. This is reflected in the range of difference in their C/P ratio which for all three hearings was less than two percent. The uniformity of the committee members is striking when compared to the three different (composition wise) groups of testifiers. It is clear that the August 20 group invoked greater dialogue than the December 21st fellows. A lower conversation participation ratio also implies greater interest in what the person testifying had to say. The best individual responses were those of Sidney Garfield of Kaiser Permanente with a fifty percent ratio and Harold Wise with a sixty-two percent ratio (see Table III). In fact, as we shall see, there was a great committee interest in the Kaiser pre-paid plan and in what Mr. Wise had accomplished in the South Bronx. The generally poor C/P ratios of the consultants (generally over ninety percent) is a reflection of their function. They were present not to invoke discussion but to provide commentary. As mentioned above, except for one meeting (October 22) where the chairman ran a "tight ship", the consultants outtalked those testifying 90 to 67 pages (August 20) and 48 to 24 pages (December 21). Even on October 22 the consultants C/P ratio of ninety-one percent reflected their tendency to make certain things clear

rather than engage in discussion. These ideas are further substantiated by the December 21 meeting. The testifiers, Mr. Hess, Mr. Newman and Mr. Weissman (C/P ratio ninety-seven percent) were essentially functioning as one-time consultants. Their total number of pages were significantly less than others who had testified (see Table IV) and were more in line with the majority of consultants (see Table III).

The last question we must consider before discussing group processes is who were the most eloquent - who participated the most. For the committeemen, the three chairmen - Mr. Wilson, Mr. Cook, and Mr. Klutznick as well as Mr. Smith - were already implicated. It was also remarked that Mr. Klutznick talked extensively from the chair as well. Table V answers our question insofar as the consultants are concerned. The most verbal with 16.3% of the total number of pages occupied was Mrs. Somers. She attended all three sessions (the only one of the consultants who did so), and as described in Chapter II, was a favorite at the opening conference. If you were to calculate on a per hearing attendance basis, Wilbur Cohen would receive the gold medal. He made the most comments of all the consultants and talked for 12.7% (forty-nine pages) of the total number of pages. Those present were fascinated by his remarkable store of knowledge and his realistic commentaries on the political processes in the health care field. Other major contributors in decreasing order were Walter McNerny of Blue Cross and Daniel Pettengill of Aetna. It must be kept in mind that this discussion makes a sometimes

fallacious assumption, increased input is directly proportional both to relevancy and effect on the final product, the committee report. Whereas this is usually the case, there are important exceptions.

In summary:

The committee, a homogeneous concentration of business interests, beset with numerous conflicts of interest was stifled by excess patriarchy, the latter resulting in poor attendance and limited participation by individual members.

Committee power was concentrated in a core nucleus which functioned in a semi-autocratic manner making major decisions, appointing consultants and deciding who was to testify without prior committee concensus.

Consultants, with numerous and significant conflicts of interest of their own encompassed (along with those who testified) a narrow centrist philosophy designed to maintain the viability of the private sector.

Processes of Group Interaction

Group dynamics implies the action of the complex and interdependent forces interacting among individuals in small groups. It is well known that:

> change can be accomplished by the use of group meetings in which management effectively communicates the need for change and stimulates group participation in planning the changes.[1]

It is another common political tradition to assign problems such as the health crisis to groups or task forces. This practice is based on the promise that in a deeply integrated pleuralistic society there is commonly an expression of diverse and often individual needs which require delicate resolution in the form of intricate and flexible solutions.

I have claimed that the committee was controlled in a semi-autocratic fashion by a core nucleus of power interests. Substantial evidence has been presented to confirm this hypothesis. Further examples will follow. The questions raised are: 1) What are the consequences in terms of group processes which follow from this assumption? and 2) can we demonstrate any of these consequences at work in the Steering Committee? Definitions will be supplied where applicable. The Rockefeller Committee originally had good intentions in terms of group interaction. A two hour meeting among committee members (alone) had been held on June 22 at the University Club in New York. The main issue of the day was to separate members into two sub-groups (one financing, the other organization and delivery) to maximize the opportunity for group interaction. It was stressed that this division was necessary to promote healthy group psychology. Unfortunately, political circumstances (see Chapter VI) intervened and the necessity of meeting an earlier than planned deadline cancelled the original plans.

Studies have shown that highly structured groups proceed in a more direct and open manner, are more task oriented,

seem to move quickly to surface communication and surface relationships and showed greater deference to persons of power and authority.[2] This is essentially a description of the Rockefeller committee structure, courtesy of Victor Weingarten. Communication, albeit often superficial, flowed easily. There was never a pause at hand - a loss for words. The problem was clearly defined; the task was to hear testimony and suggest solutions. Examples of the structure and deference to the chair are easy to find. In his opening statement at the October 27th meeting, Chairman Wilson addressed those testifying:

> We hope that you will find it possible to speak informally and briefly and let us get engaged in discussion as promptly as we can.[3]

That same morning, Mr. Grey requested permission to ask a question.[4] Mr. Grahm asked to speak informally, proceeded to read his speech verbatim from a prepared text. At another point, consultant Anne Somers was required to ask for five minutes to speak and Mr. McNerney suggested "maybe we are upstaging Anne".[5]

Experience has also revealed that autocratic groups show less independence and interdependence and therefore, increased dependence.[6] The achievement of interdependence is the ideal goal of the successful group. Interdependence is that state in which cooperation and collaboration are optimal while independence of judgment and action are maximized.

With interaction minimized by poor attendance and limited participation, the Rockefeller committee hearings were dominated by an air of dependency in which individuals ceased to rely on their own judgments yielding to those in the leadership position. It wasn't until the first draft of the final report had been written and distributed by the "core nucleus" that features of individual independence were in evidence (see Chapter V). Action postponed until a report is issued by a semi-autocratic leadership is too late. Effective group interdependence must develop from changes in standards, roles and patterns of communication with subsequent often painful restructuring of relationships into new configurations:

> The mark of a group is its concern for human emotion. The right to one's feelings and the right to express them is keystone. Awareness of the feelings of others has a high premium. The exercise of these rights so based, creates a profound sense of freedom. The individual finds himself learning, and changing as his implicit and explicit expressions are noted, pondered upon and reacted to.[7]

The source of the dependency among these traditionally super independent business leaders is not difficult to explain. Appointment to the Governor's committee involved recognition by the Governor and the resultant status associated with his name and position. It is well known that status and dependency are often intimately related. It is also common knowledge that groups are often subordinate parts of larger units

which exert powerful influences over the smaller groups. The businessmen were well aware of both the personal gain and possible business advantages to be achieved by serving on the committee. Nowhere is this better illustrated than the current ITT affair. Outside their areas of primary expertise, and with the knowledge of the social and other implications of this favor to the Governor, they were content to occupy a back seat position.

It has been recognized by Hemphill in his work entitled A Proposed Theory of Leadership in Small Groups that people will tolerate authority and autocratic leadership in large groups, as opposed to small ones.[8] Maybe, in their attempt to set up sub-groups, the core nucleus was trying to prevent a situation where decisions would stem from the chair. Also interesting is a study by Sherif[9] (substantiated by Aschl[10]) which shows experimentally that even the most independent have a tendency to yield their judgment and depend on others in the face of consistent opposition and, particularly when the subject is ambiguous. Thus, with the lack of a sustained motivation to engage in group interaction and achieve a measure of interdependence, committee members were in a perfect situation to bend their minds in the direction of the consultants who, as mentioned, several times previously, were middle-of the roaders, who often dominated committee discussions.

Probably one of the worst instances of the effects of autocratic leadership was illustrated by Mr. Cook while in possession of the chair on the afternoon of the 27th of

October. The committee was behind and to increase efficiency he structured the P.M. session so as to allow forty-five minutes for each of three speakers. Mr. Roth of the American Medical Association had spoken about forty minutes whereupon Mr. Cook accused him of over extending his limit by fifteen minutes. Mr. Roth was surprised and stated, "I am sorry. I thought I had forty-five minutes".[11] Mr. Cook then instructed him to finish his commentary, an additional one or two minutes. Following this, Mr. Roth was subjected to a barrage of questions, some of which contained definite elements of hostility:

> Chairman Cook: If he has a large family and carries a heavy load; you have no premium at all for, let's say, the population explosion, isn't that true?
> Mr. Wilson: They go at that through another mechanism.
> Mr. Weingarten: What do you do with the millionaires under this system who pay no taxes at all?
> Mr. Wilson: There are only twenty of these.
> Dr. Roth: All I am saying is the offset of what they ought to be paying in taxes is only going to be increased by $600, so it isn't going to hurt badly.[12]

Under the same forty-five minute guidelines, aggressive well-liked George Melcher of HIP over-stepped his limits mentioning he would quit two times thereafter, but not finishing until six pages hence. The reaction was not negative. Mr. Melcher was not admonished. After an additional nine page discussion section, Chairman Cook praised Dr. Melcher stating his discussion, "to be stimulating and a very good contribution."[13] The bias was blatant. Mr. Cook had effectively

illustrated the tendency toward aggression against scapegoats exhibited by autocratic groups.

Conflict is common and acceptable in group psychology. The democratic group rewards power to a leader who is able and ready to perceive subtle changes in both himself and other members of the group. Conflicts generate significant charges and countercharges and may be expressed as covert or overt hostility. Members will, sometimes without even realizing what they are doing, take sides. A democratic group respects the affected individual's right to a metaphorical writ of habeas emotum. This means that the group will lay aside its other activities and give precedence to the claimant who demands a fair and open hearing.

Conflict is intimately interrelated with communication, usually implying a breakdown in the latter. Communication may increase toward deviate members and may cease altogether if the deviate moves too far from the standards and norms of the group.

Mr. Russell, Vice President of Pepsi Cola, and the only minority member on the committee is a case in point. He spoke eleven times at the August 20th conference. The majority of his comments concerned medical service for the underprivileged and the plight of the community. He had fought quite hard (see Chapter II) at the Governor's Conference for the idea that health care was a right. He had even opposed the Governor, a close friend, face to face on this issue.

Mr. Russell's role in the committee and in other aspects of his personal life was a defender of the community. On the whole, there was very little discussion of community participation and community control. It was obvious to myself that Mr. Russell began to withdraw. His individual morale began to drop. He came four hours late to the October 27th meeting and never said a word. He did not appear at the December 21st meeting because of a conflicting appointment. No effort was made to change the date on his behalf. No effort was ever made to provide Mr. Russell with a writ of habeus emotum.

Conflict is an essential element in group interaction when not directed against a single individual. It is the impetus which leads to interdependence. Conflict is most often expressed in what is known as the fight-flight modality. The fight aspect is overt, the flight component usually covert. Flight identifies the many different ways in which the group escapes temporarily from the task for which they are organized. It's basically a means of releasing pressure.

Two expressions of flight are cited from the Rockefeller experience. The first involves the use of rumor. A frequent topic in private discussions was the Governor's then current campaign for reelection. This was a source of tension because: 1) a number of the Governor's best friends were present including a close aide, Barry Van Lare, and 2) there was a significatnt chance the Governor would not be re-

elected (with all the subsequent political consequences attached to this notion). Thus, numerous rumors would spread relating to loss of the Jewish vote, plots of Mayor Lindsay, and possible repercussions of defeat on the committee. The possibility of a Nixon cabinet appointment was also mentioned. Rumors flourish around regions of high potential, i.e., around persons or sub-groups exerting strong influence.[14] Theoretically, they are viewed as reflecting anxieties and hopes of individuals as they struggle against other unknown factors the health crisis and its complexities in the Rockefeller case.[15]

Similarily, humor is another escape or flight mechanism. Great satisfaction is achieved from the resultant discharge of feeling and accompanying sense of relief. Several participants in the conference used this technique. Wilbur Cohen and Mel Glasser both started off their talks with jokes. Perhaps, the individual with the most sophisticated and frequently invoked sense of humor was George Silver. He had the whole crowd literally "rolling with glee" on several occasions. Chairman Cook introduced him as an individual, "who could keep us here not only awake and alive for a long time, but sitting on the edge of our seats." Dr. Silver's response was classic: "Thank you. After that, what I ought to do is to keep quiet and live on my reputation."

In terms of our system's analysis model, group processes or group dynamics is concerned with the mechanism of operation of the processor. We have claimed that the pro-

cessor operated in an autocratic, highly structured, task oriented manner with individual members assuming a dependent rather than an interdependent status. Poor attendance and limited participation were among the factors which permitted the consultants to dominate the hearings and to a significant degree, the processor as well (Aschl's theory). Further, the autocracy of the chair was occasionally reflected in aggression toward scapegoats and failure to provide a metaphorical writ of habeas emotum for those committee members, like Mr. Russell who had experienced communication difficulties. The pressure of conflict when not directed toward single individuals was deemed healthy and was, at times, reflected in various flight processes such as rumor and humor.

CHAPTER V

THE GOVERNOR'S STEERING COMMITTEE ON SOCIAL PROBLEMS: REPORT ON HEALTH AND HOSPITAL SERVICES AND COSTS

Introduction

In this chapter we consider the final product of the committee: its origins, derivation and frame of reference. It was the summation of eighteen months of careful planning and organization, over twenty-four hours of testimony, and innumerable man-hours by some of the most prestigious figures in the business world. It was the product of hearings whose gestault was totally consistent with guidelines set forth by May 14 Conference workshops molded by the Governor's participation.

The report was issued by a committee whose semi-autocratic "core nucleus" supressed group interaction to such extent that the interdependence which characterizes group (versus individual) superiority never developed. The committee hence became a front for independent action when, in truth, it was dominated by a "core nucleus" which was very sensitive to the wishes of the Governor.

It is in this context that the report is described and discussed. The political ramifications of the latter is the subject of Chapter VI. The present chapter seeks to describe the extent to which the report reflects the opinions of 1) committee members; 2) consultants; and 3) those that testified. It also attempts to describe some reactions of committee members to the final product.

Genesis

The report, in its entirety, was written by Victor Weingarten and staff utilizing input from the hearings (Chapter III) and an impressive bibliography to which the committee was never exposed. It must be stressed, that unlike the hearings, the consultant oriented outcome to be described did not result from supression of committee opinion. A draft of the final report was mailed to committee members in late January, 1971. The report was divided into two major sections: summary of findings and a summary of recommendations. The latter in turn had been separated into divisions on national goals, consumer participation, the health care system, the need for a community health care system, manpower, financing and national health insurance. Following the distribution of the draft, each committee member was asked to submit his reactions and criticisms to Victor Weingarten. Only three did so: R. Heath Larry, Phil Klutznick, and Harry Cunningham.

Harry Cunningham's letter was a blanket approval of the first draft:

> I have the strong impression that your report covers quite well the most constructive ideas so far advanced in the committee's meeting.[1]

Mr. Klutznick has already been cited for his valuable contribution at the health care hearings. His comments on the first draft constituted a precise reordering of the text of the entire summary of finding section. His seventeen suggested changes in wording were acted upon and appeared as stipulated in the final report. Klutznick clearly felt that it was important for the summary of findings section to have a strong impact: "If the findings are clear, we can move on to the rest later."[2]

Heath Larry's criticisms were more substantial. He criticized the use of "over dramatic language" stating that the utilization and intensity of the verbosity and "acid adjectives" was often proportional to the degree of insubstantiality of the statements.[3] He was also doubtful of the truth of the contention that Kaiser-type premiums were "fifty percent" lower than that provided by the private insurance system.[4] Insofar as short and long term goals, Larry favored short term planning but then questioned whether any initial action would necessitate thorough study and evaluation before additional "long term" goals were pursued.

Federal incentives for a private restructuring of the health care system were fine, but not governement financing for any but the indigent and near-indigent:

> It seems to me that the great minds in the health field could come up with a scheme that might amend the present Medicaid law to take care of these people without having to establish a complete national financing scheme....I would be very fearful of opening up a broad scale program to continuing support from the general revenues.[5]

Larry's comments were well illustrative of the traditional laissez faire republican orientation of American business. The latter had greatly influenced the committee from the start of its study.

The Preliminaries

The report was dated June, 1971 but was actually completed by April 15. The forward was written by Joseph Wilson and C. W. Cook. It expressed appreciation to the Governor, the Secretary of HEW and White House staff. The committee had met with the latter two in February, 1971 (see Chapter VI). The keynote of the report was the rational managerial evaluation of the health care system. The committee was to identify weaknesses where they existed and attempt to propose practical and economical solutions.[6] The judgments were of a lay character but based on testimony from leaders in the health care field and the "expert opinion of some of the best in-

formed professionals" in the field.[7] It was stated that the committee had accelerated its work so that its findings and recommendations could be of assistance in the current push for health reform. The committee also expressed thanks to Mr. Weingarten but did not mention that he had researched most of the material for the report, had written the draft and the final copy and had neglected to distribute copies of the bibliography to individual members to insure informed approval of the final product.

Summary of Findings

The opening section of the report described the astounding medical progress the committee discovered. The "best of American medicine" was described as being without equal. There was no attempt to minimize "very significant strengths and contributions."[8]

As might be expected, the section was dominated by a critique of the health system. The manpower shortage was a myth. The real faults were maldistribution and a continuing trend toward overspecialization.[9] Restrictive licensing was scored as a means of making the "process of ossification legal and self-respecting."[10] The report made the claim:

> Virtually every State has legislated some restrictive practice at the behest of a specialized professional group zealously guarding its status.[11]

Medical education was not immune either. The system as a whole was termed unresponsive, but the AMA was not directly implicated. Most of the manpower deficit was in general practice but the medical schools had, in the committee's words, "continued to encourage their students into more and more esoteric super specialities."12

The report outlined in detail the number of existing health facilities and the number of beds in those facilities to illustrate that the latter also suffered from maldistribution. A borough like Manhattan had "wall to wall" hospitals where other parts of the city were lacking. The facilities they did have were "antiquated relics." Needless competition and waste of scarce resources and funds was scored as well. Hospital boards were criticized for their independent operation and "self perpetuating" boards of trustees who determined, without any formal training or consideration of total needs of community or state, purchase of expensive equipment and construction of facilities. Further, the institutions had managed to gain control of the health planning councils (RMP) producing a situation humorously depicted: "In effect, the flies have captured the fly paper."13

The manuscript highlighted the problems of inefficient, ineffectual and irrational organization which existed in a fragmented system in which quality was largely unmonitored and subject to great degrees of variance. Failure to pool skills and facilities had even resulted in loss of life.

The committee stressed that both care and facilities tended to go where the money was. The indigent, plagued by inadequate health care, were at times receiving inexcusable treatment, had been greatly discouraged by the sudden deflation of rising expectations (i.e., Medicaid) and hence, were often the leaders of a rising and widespread wave of public discontent. Too much emphasis had been placed on high cost "curative" treatment and too little on low cost health maintenance. Finally, the entire system, organized for the convenience of providers (versus consumers), was unmotivated by a host of disincentives. The committee attacked so called health insurance as "sickness insurance." They estimated that thirty-three percent of all hospitalization was unnecessary and that twenty-five percent was essentially for insurance purposes. There were far too many surgeons and far too much surgery. It was estimated that twenty percent of all hospital surgery could be done on an out-patient basis.[14]

In fact there was a great misconception that health services in fact led to better health. The committee stressed the fact that the major causes of sickness and death were being largely ignored.[15] The report, in its best lingo, summarized:

> We operate not on scientific evidence about the causes of sickness and death, but on the very complex psycho-social and economic needs and demands which continue to emphasize cures at the expense of causes.[16]

The main thrust of the summary of findings chapter was the hypothesis that existing resources were more than adequate to provide comprehensive care to all Americans if used more efficiently. By applying a system such as Kaiser to the general population and taking into account the reality of a fully representative population, it was estimated that an acceptable level of care could be provided to all at a 13.5 billion dollar savings.[17] This figure was $227 per capita versus the present $294 and Kaiser's $170. As a corollary, the report estimated increased ambulatory utilization would result in an excess of 350,000 short term beds and the use of pre-paid group arrangements in an excess of 92,000 physicians and 800,000 semi-skilled professionals.[18]

The committee did not take its estimates literally:

> We recognize, of course, that in a free society where neither manpower nor facilities can be moved around like chessmen such a rational, orderly distribution is not possible.[19]

The emphasis was not on the figures but on the room for manuevering toward a more rational system through "more efficient and effective use of expensive facilities and services."[20]

The summary of findings chapter was "impressed" by the number of past "meritorious" proposals for change which were ignored and by the ability of the profession to resist change.

The closing statement was that one could not finance a system and ignore organization, delivery, and manpower. They were all interrelated, interdependent. The report warned that to ignore this basic law of medical care would be to create a situation which would force "government takeover."[21] The latter was undesirable and vigorously opposed by the committee.[22]

Summary of Recommendations

This section comprised the remainder of the report. The committee first outlined a series of factors and principles which they felt constituted an adequate base for a national health program. Any program would have to consider national goals, reorganization of the delivery system, manpower, financing, and consumer responsibility and public participation.

The report promoted a pluralistic approach favoring multiple opportunities for competitive systems. The ideal system would be an intermix of private enterprise, the medical and allied health professions, and the unique fiscal and legislative capacities of government. The stress was on "the flexibility, innovation, efficiency and managerial skills of private enterprise."[23] Any legislative plan enacted in phases or stages was to expand by means of a preordained time schedule. The report pushed for profit and non-profit pre-paid group practice, quality and cost controls, direct

federal subsidy of medical education and research and avoidance of a two class health care system.

Formulation of National Goals

The report stressed the need for the formulation of a clear definition of national health goals as a "vital first step" in the reorganization of our delivery system. The committee proceeded to set forth a series of five reasonable, minimum goals for the 70's. It was felt 1) health care should be both available and accessible to the entire population; 2) that high priority should be assigned to the needs of the poor and the near-poor; 3) that as "rigid monitoring as possible" be applied in combination with incentives for quality and cost control; 4) that maximum leverage for change accompany the input of all public funds into the health care system; and 5) that the financing of health care should be tripartite: government, individual and employer. The emphasis was on health maintenance and lower cost, more efficient ambulatory and home care.

One of the most controversial sections of the report dealt with the delicate subject of euthanasia. The report stated that:

> the committee believes that the percentage of the gross national product spent for health care should be reviewed in view of the ever increasing costs of prolonging life for the very aged and infirm persons

with no hope of recovery.[24]

It argued for discussion and debate of the issue because of questionable utilization of expensive services and scarce personnel.

The committee pushed for the formation of a Council of Health Advisors in the Executive Office of the President (versus HEW) to analyze and interpret trends in the health care field, appraise and recommend federal policy, prepare periodic health studies, and make an annual report to the President and Congress. DHEW was scored for its political defensiveness and general lack of assertiveness in its failure to exert a "vital, major role" in the reshaping and rationalization of the health care system. Similarly, Congress was cited for its divergent approaches and perpetuation of special interests in a fragmented committee system with frequently mitigated against orderly, rational programs. The report recommended a higher degree of inter and infra-governmental coordination.

Consumer Responsibility and Public Participation

The committee expressed its view that the country could never (no matter what percent of the GNP was involved) provide sufficient services to treat everyone that succumbed to illness.[25] In view of the latter, the report called for a tremendous creative, multi-faceted effort (with continuity)

to promote health education. The committee recommended creation of a National Center for Consumer Health Education within DHEW staffed with imaginative leadership. A series of seven areas were outlined to serve as the nidus for national policy formulation.

The report recommended a revitalization of the U.S. Public Health Service for the purpose of assuming control of and operating existing child health programs. The committee viewed the infant and school age population as the area in which to begin if one was going to catch up with the tremendous backlog of health needs.

Consumer participation in health planning was encouraged but limited to areas of special competence. History had shown that providers, when left to themselves, tended to develop programs and institutions which to a large degree were "self-serving and designed for their own convenience."[26]

The Health Care System

This was the first of two parts of the report directed at the rationalization of the organization and delivery of health care services. There was an urgent need for utilization of modern technology and sound management criteria in seeking solutions to manifold problems. More efficient and significantly less costly ambulatory services (fully integrated in a comprehensive services system) were to replace and achieve higher priority than expensive less efficient in-

patient hospital services. To promote ambulatory care a revitalized and reformed hospital with a stronger and more flexible internal organization would serve as the core for the development of a meaningful system of comprehensive health care at the community level. Other desirable alternatives (HMO's - Neighborhood Health Centers, etc.) were encouraged as well as a good measure of innovation and experimentation. New delivery systems

> would encourage better organization and economy of use of manpower, facilities and funds while enhancing the quality and effectiveness of care.[27]

The committee recommended that federal funds be shifted from support of inpatient facilities to provide loans and grants for construction, planning, startup and stabilizing costs of ambulatory facilities. Wherever possible private rather than public involvement was to be encouraged.[28]

Comprehensive health care meant "the right patient in the right bed at the right time." This motto described a system which offered a whole range of facilities providing alternative levels of bed care in addition to the hospital and nursing home. Its essence was a cohesive well integrated network with centrally situated supervision, information, referral, placement and planning.

The report stressed:

> every gap in treatment and preventive services and facilities (as well as financial coverage) guarantees

> an overload on the rest of the system at some point, usually on the hospital and the nursing home.[29]

The Need for a Community Health Care System

The report stressed the need for a "radical shift in national policy"[30] to stem the tide of rising hospital costs. The model ambulatory care system was explicitly defined. All patients would receive transportation to neighborhood centers and hospitals which would adopt utilization control, hospital discharge planning, geriatric patient reassessment and placement and a complete range of restorative and rehabilitative services. Multiphasic health screening, health maintenance, reliance on papaprofessionals, low cost home care and semi-independent living facilities were suggested to prevent costly in-patient incarceration of the elderly.

Hospitals, HMO's or health care corporations, were to be publicly accountable for the delivery of quality care. Meeting established publicly defined criteria would be a prerequisite for the receipt of all federal monies. The committee recommended a system of prospective budgeting and controlled charges and even saw the possibility of eventual public utility flat rate regulation. The Federal government was to set minimum standards but state, regional and local officials would administrate the new program.

The model ambulatory system was for the future. The committee recommended a series of immediate reforms based on modern managerial techniques and cost efficiencies. Represen-

tative and strongly independent community health planning agencies (group "B" agencies) were to receive authority to direct public funds to high priority essential grants and contracts. Appeals were to be made to a newly created state agency which would control institutional review as well. The agencies were to emphasize efficiency incentives, machinery for internal planning and system's development, utilization controls, combined purchasing and cooperative use of services and facilities between neighboring institutions. No payments were to be made for "unnecessary" services or for charges exceeding the prevailing level in the community. Institutions were to share in the profits derived from their economies.

The final portion of the section was a reiteration of Dr. Silver's analysis of the possible reallocation of federal funds. Some changes required only administrative directives, other Presidential intervention, and still others, legislative action. The purpose of redirecting duplicating, overlapping fund mechanisms was explicitly defined:

> The force of our recommendations is to stimulate improved organization of health services and manpower, particularly for serving the poor and deprived, but beyond that to promote and foster systematic change that will offer a useful and attractive service available to all classes of citizens.[31]

Manpower

The problem was acute maldistribution, over-specializa-

tion, excessive and restrictive licensing and misutilization of personnel. The role of the physician would have to change considerably to achieve the magnitude of organizational change required. Much care given by the physician did not require a M.D.'s level of training.[32] The committee recommended rapid expansion of paraprofessionals of all gradations of training and responsibility. Federal financing of upward mobility programs was encouraged to reduce job dissatisfaction and a consequent rapid urnover rate.

The report recommended a National Office of Education for the Health Professionals within DHEW. Its job would be to provide an intelligent, comprehensive and orderly long range approach to the problems of health manpower. To end restrictive licensing, the report urged the adoption of uniform federal task definitions for all health professions with a stipulation that those states not accepting such definitions be denied federal financing. To increase the output of existing medical schools, the committee desired: 1) reduction of the medical curriculum from four to three years; 2) reduction of graduate medical education by one year; 3) institution of six year program from high school to the M.D. degree; and 4) utilization of medical school facilities during the three summer months. The report also pushed for financial incentives to increase the number of primary care physicians and recommended that M.D.'s, in lieu of military service, be permitted to serve a needy American community

for a two year period.

The committee recommended expansion, consolidation and coordination of all federal manpower training and scholarship programs. Top priority was to be directed at the delivery of primary ambulatory care to rural and ghetto areas. Also urged was: 1) extended long term low interest loan support for the complete cost of medical education; 2) waiver of one-third of loan obligations for each year of service (with full compensation) in an area of need; 3) direct support (through grants) of medical schools for educational purposes; and 4) a five year period of grants to physicians and allied health personnel who agree to serve in areas currently lacking adequate health care.

Health Care Financing

The report came out in favor of a national health program but refused to endorse any one plan. Instead, a two phase program was outlined. The first phase was a set of immediate reforms (see next section); the second a series of long term measures to be undertaken after evaluation of the initial changes. The importance of federal leverage was stressed for a third time. The report viewed the current "urgency" for change as dangerous to meaningful reform and requested careful consideration of all relevant factors. It predicted that the health care "crisis" would be a major

issue in the 1972 election campaign.[33]

The nine guidelines set forth in the report were those Anne Somers had prepared for the December 21 meeting. Even the texts below each statement were taken verbatim from her presentation. The reader is asked to refer to Chapter III for further information.

Steps Toward Universal Access To Health Care

This, the final section of the report, outlined some immediate means of changing the system. It too was a modification of Anne Somers' text, "A Proposal for Strengthening the Financing of Health Care in the U.S.". The report claimed that the private carriers, negligent and derelict in the past, had had a new awakening:

> We believe, however, there is now recognition and awareness by all concerned that the present situation, posing new challenges, will have to be met more aggressively and differently if the private and Blue Cross insurance role is to survive.[34]

To strengthen the private sector, the committee endorsed a set of federal minimum standards and increased federal financial support of HMO's. The report scored labor and industry for not asking sterner questions about what they were getting for their insurance dollar.[35]

The committee recommended the working population be covered by a mix of equal employer-employee contributions and federal subsidies. If an employee's income fell below the limits set for the poor, his benefits would continue financed by funds derived from general revenues. As an incentive to work, his benefits would exceed those of the non-working poor. These additonal benefits were to be financed by tax credits or supplied by employers as fringe supplements. It was expected that the basic program of benefits, financed as stipulated, would encourage and accelerate the purchase of additional coverage from carriers including preventive care and alternatives to expensive hospitalization.[36]

Medicare was to remain largely unchanged. The elderly indigent would be eligible for further tax support based upon their income status. Medicaid was to be totally federalized and subsequently financed through general tax revenues. Private carriers, preferentially through high risk reinsurance pools, would provide coverage under newly legislated federal minimum standards. A massive, energetic advertising campaign would be necessary to reach those involved. Even still, the committee allowed a period of one hundred twenty days of retroactive coverage for eligibles who were "unreachable." The medically indigent, much like the HIAA proposal, were to receive a descending scale of federal funds for insurance premiums.

On the whole, the report was excellent. It was well written, concise, and provided a comprehensive overview of the health crisis both in its findings and recommendations. Its theme was the rational managerial evaluation of the health care system.

The report effectively highlighted the problems of inefficient, ineffectual and irrational organization which existed in a fragmented system in which quality was largely unmonitored and subject to great degrees of variance. Its "ideal" replacement was a system utilizing an intermix of private interprise, the medical and allied health professions and the unique fiscal and legislative capacities of government. The report emphatically stressed that maximum leverage for change accompany the input of all public funds into the health care system. Emphasis on health manpower, lower cost ambulatory and home care, pre-paid group practice, tripartite (government, employer, employee) financing mechanisms and use of federally regulated private carriers were all keynotes of the manuscript.

The report courageously broached the subject of euthanasia and strongly endorsed health education. Its greatest weakness was its relative deemphasis of consumer participation and control. The report did not endorse any one national health program but instead outlined Anne Somers' series of nine criteria for change and emphasized the need for flexibility. The report stressed the huge hiatus between health

and health services and pushed for greater consideration of the major causes of sickness and death.

Derivation, Analysis, and Frame of Reference

Derivation

The report, written by Victor Weingarten, was largely the product of the beliefs and principles of the consultants and Mr. Weingarten's painstaking research. The foreward had stipulated that judgments were of a lay character but based on the testimony of leaders in the health care field. I think they forgot to mention that the accent was strongly on the latter. Evidence of committee input was limited to a few rather than the group as a whole. The latter was much like the situation which prevailed during the hearings (see Chapter IV).

Most of the factual material originated from the basic readings and from Anne Somers' text The Paradox of Health Care: Crisis Born of Progress. The phrases "best of American medicine," "techniques verging on the miraculous" were examples of Somers' lingo. Information regarding sickness insurance, blessings of pre-paid group practice, the need to avoid a two class system of medical care, emphasis on comprehensive care and prevention and the interrelationship of organization, manpower and financing were all familiar land-

marks to anyone who has had any experience with the health care crisis. A stong point was made of David Hapgood's development (see Chapter III) of restrictive licensing and lack of vertical mobility in the health professions.

The report, above all others, was based on the views and writings of Anne Somers. Not only were a large number of her facts and figures utilized, but her two main contructs on organization and financing (see Chapter III) formed the nidus for whole chapters. Her hospital model, now endorsed by the American Hospital Association, was the focus of the comprehensive services section of the article entitled "The Need for a Community Health Care System." The report even reiterated her invitation to develop competitive systems as a means of comparison and evaluation. The committee's guidelines for a long-term solution to the health care problem were extracted verbatim from her prepared text. The section on immediate modifications of the health care system is also a close relative of the original Somers' text. The proposal for federalization of Medicaid was based on the recommendations of the Medicaid Task Force (June, 1970) and Walter McNerney's comments at the hearings.

Other differences between the final report and the original Somers' manuscript may also be traced to specific opinions and influences. The committee incorporated Mr. Weisman's criticism that national minimum standards be enacted as part of the first (rather than the second) step

towards a national health program. The specifics of employer-employee contributions with government subsidies were consistent with Mrs. Somers' views but also closely paralleled the content of Governor Rockefeller's four proposals for universal insurance in New York State. Mrs. Somers' plea for federal licensing of carriers is largely omitted on the basis of committee member Klutznick's view that the states would not permit any ursurpation of their constitutional rights. The reader may recall (see Chapter III) that Mr. Klutznick instead called for ingenious use of "federal leverage" in connection with revenue sharing. The committee's failure to adopt Mrs. Somers' concept of a "medicare core program" is traceable to the California UDP experience (see Chapter III) in which the public plan eventually "did in" its private competitors.

I'm sure one could go on adinfinitum but the point of this and following discussion is to stress the domination of the report by Mrs. Somers and the other consultants. Mr. Klutznick's thoughts were the only committee member's (with the possible exception of Mr. Larry) to be effectively incorporated into the final product.

Walter McNerney's influence was alluded to twice already. He was also responsible for the need to set goals and priorities even though the actual goals themselves were attributable to others as well. The committee's point that the major causes of illness were being ignored was directly

related to McInerney's remarks that health services did not necessarily lead to improved health.

The others present at the hearings can also be implicated in one way or another. The dependence on the private carriers, the avoidance of core medical program, the omission of the disabled, the new awareness of the private insurers and the concept of a statewide reinsurance pool may all be traced to remarks made by Daniel Pettengill while representing the Health Insurance Association of America. The use of federal leverage ("clout," "selective intervention"), was expressed by no less than five to six different parties (see Chapter III). Mr. Grahm of the American Hospital Association was the first to mention "prospective budgeting" (at the hearings) but the idea was promoted by Cohen and Pettengill as well.

Many of the key issues in the report originated in the hearings. The mention of euthanasia was largely traceable to Arthur Hess' discussion on December 21, 1970, while the idea of a Council of Health Advisors was derived from Anne Somers' chapter number VIII in Paradox of Health Care. The need for reorganization of HEW and Congress, first mentioned in the Medicaid Task Force report, represented the core of George Silver's main assignment. His explicit means of redirecting existing federal funds to promote useful change was reproduced at the conclusion of the chapter entitled The Need for a Community Health Care System. The report

also incorporated Sydney Garfield's emphasis on free choice of delivery systems; George Melcher's promotion of direct federal subsidies for medical education; and Dr. Cherkasky's plea that any new system give priority to the needs of the poor. The need for regional medical programs to possess and utilize authority in deciding priorities was first broached by Mrs. Somers' text and then reconfirmed by Dr. Knowles' October 27 tirade as well.

Dr. Cohen's contributions were more subtle since he proposed fewer definitive programs. He, above others, emphasized the need for gradual change and phasing - a striking feature of the final product. It was also his contention that greater and greater controls would be necessary. The report responded by citing the possible eventual necessity for public utility regulation of HMO's.

The concept that the report, on the whole, did not reflect committee opinion but rather consultant and testifier input is important. The processor, in terms of our system's analysis model, mostly served as a porous filter which carefully selected its input and then methodically organized its content to create the final product.

Analysis

The most original section of the report was the discussion of manpower. It is also one of the few examples in which the content of the consultant dominated hearings was

not mirrored in the final product. Its ideas and constructs were largely the product of Victor Weingarten's painstaking research. He had even traveled to the State of Washington to collect information on the Medex program. It is a paradoxical situation in that the manpower issue was largely ignored at the Governor's Conference (see Chapter II) and was hardly mentioned during the hearings. A second paradox was that it, along with consumer health education, and above all other topics, was to have the most political leverage (see Chapter VI).

Another striking example of committee input was Peter Warter's analysis of the possible savings attributable to a nationwide application of the Kaiser system. Mr. Warter, Division Manager at Xerox, had computed the figures in response to a discussion generated at the closing session of the May 14-15 Governor's Conference. The issue was also the most controversial in terms of committee interaction. It comprised both Mr. Larry's (see earlier) and Mr. Klutznick's main criticisms of the final report. Klutznick stated:

> I have some doubts about the mathematics used with respect to potential savings through group prepaid plans. While I endorse the emphasis on encouraging such plans, I am not certain the evidence supports such savings.[37]

Harold Wise had made a similar statement at the August 20th hearing. It was his opinion that group practice costs would rise as they provided more complete care to their clientage.

A final consideration was the supposed emphasis of the report on managerial infusion. The issue was well covered. George Melcher, in the October 27 hearings, had illustrated, in detail, how the newest and often most complex managerial techniques and cost controls could be successfully applied to a pre-paid group practice (HIP). Considering that the subject was the primary reason for having businessmen, such as the Rockefeller group, construct judgments on a highly complex health care system, its importance was relatively understated in the final product. The topic was mentioned several times and even thoroughly developed in a sub-section entitled "Improving Cost and Quality Controls." However, as implied, it never dominated the final product - it was not the essence of the report's recommendations. A possible reason for the latter is that the importance of managerial efficiencies had been devalued by Dr. Silver's contention that the institution of pre-paid group practice would, in the long run, produce far greater savings than the combination of all managerial improvements.

The reason for singling out the managerial issue is its importance as a landmark - a means of identification for the committee. From the start it had been fixed as the justification for the health care study. It quickly became and remained an effective psychological crutch for any insecurities the committee might have had by virtue of their trespassing on heretofore forbidden intellectual territory.

Frame of Reference

The Rockefeller committee report cannot be technically considered as a proposal for a national health care system. However, each of the ten plans outlined in Appendix D has a certain philosophy which is easily categorized. Certain plans such as the Kennedy (CNHI) bill view national health insurance as an integral part of our national social security system paid for primarily through payroll taxes and administered through the social security mechanism. A second category comprises those plans which involve federal subsidy of private health insurance by means of income tax credits to taxpayers and federal vouchers for the poor. A final and third approach are those programs financed through some combination of payroll taxes and general revenues with some public controls over benefits and premium rates, but relying exclusively on private underwriting.

For our purposes we can regard the Kennedy type plan as left of center (category one), the AMA-tax credit type (category two) as "conservative" and the "Rockefeller" type (category three) as middle of the road. The Steering Committee's promotion of a program operated by private carriers subject to strict DHEW standards and financed by a mix of equal employer-employee contributions with federal subsidy is clearly an exposition of the basic Rockefeller concept. The role of government was explicity limited:

> We envision the role of government as guiding, not directing; motivating, not demanding; assisting, not providing; and evaluating not ordaining. It is a key role involving policy formation, establishing objectives, fashioning incentives, evaluating results, and always protecting and promoting the public interest.[38]

The Steering Committee embraced the private insurance companies at the same time the Committee on National Health Insurance condemmed them as irreprievable failures. There was a sense of urgency surrounding the latter best illustrated by R. Heath Larry's comments (see earlier). The government was moving in. The committee was not so much anti-reform as they were anti-government mediated reform.

The centrist philosophy of the committee pervaded financing, organization and the delivery of health care. Not only was a national health program to be administered by private carriers, but it would be best delivered through privately controlled, federally supported contractors. The progressive aspect of the latter was that change would be assured through strongly-based federal financial incentives rather than by the effective planning and peer review featured in the Aetna and AMA plans.

Their ideas on the consumer were relatively conservative as well. John Q. Public would participate in the planning process but it was preferred that he be educated to do so.[39] Although it was theoretically clear that meaningful consumer input was necessary, the report failed to address itself to the "how" behind this. The practical realities of

consumer participation were that once the consumer was "educated" he was no longer representative of his community.[40] The committee conveniently avoided this difficult idsue.

By far, the most liberal proposals revolved around manpower and health education. The incentives to increase manpower, improve distribution, eliminate restrictive licensing, extend increased responsibility to paraprofessionals, reduce M.D. status and promote greater mobility among health care professionals comprised the most progressive demands for change in the report. In addition, they were also the most feasible in terms of inevitability of enactment. The remainder of the recommendations, including the proposed Council of Health Advisors and National Office of Education for Health Professions were either more conservative, more open to debate or more difficult to implement.

Thus, while middle of the road in terms of government intervention in financing, organization and delivery of services, the report's content with respect to the interests of the consumer and manpower was, on the whole, impressively progressive. There was, of course, the exception of consumer participation and control, but the problem here was not the necessity of the latter, but the means of accomplishing it effectively without destroying homeostasis. The Steering Committee report was significantly more liberal than the four New York State universal insurance porposals. It, in fact, was comparable to the Committee on National Health Insurance's

approach with the important exception of an inherent distrust of monolithic government operation.

It is important to remember that the report, as described, was the product of a "core nucleus" which was quite sensitive to the wishes of the Governor. This is significant in view of the obvious similarity between the report's recommendations and the Governor's philosophy and proposals. The Governor's Conference and the Governor's Steering Committee had been a front for independent action. The Governor had succeeded in using a state appointed committee to inject his personal philosophies into the current active debate for health reform. The political ramifications of the committee and its report are discussed in the next chapter.

CHAPTER VI

THE GOVERNOR'S STEERING COMMITTEE ON SOCIAL PROBLEMS REPORT ON HEALTH AND HOSPITAL SERVICES AND COSTS POLITICAL RAMIFICATIONS

The subject of this Chapter is the political ramifications of the Steering Committee on Social Problems' report on Health and Hospital Services and Costs. A number of pertinent questions are to be addressed. What did the Governor accomplish by engineering the publication of a report which, to a significant extent, reiterated his basic philosophies of health care? In what way was the report a dialogue between the Nixon and Rockefeller political constituencies? What, if any, were the consequences of the committee's recommendations and what, if any, influence did the eighteen month study have on the lives of individual committee members?

Theory

The political implications of interactions and transactions in the health care field are more often than not lar-

gely ignored. It is truly a neglected area of research.[1] The neglect of political factors in the study of public health programs and problems omits a critical element in uderstanding, planning and execution of public health services. This is especially true with respect to that area of politics which includes efforts to influence public policy.

The comparative deficiency in political research in the health care field is directly attributable to the difficulties in gaining access to the full facts. So many of the negotiations and settlements are informal and unrecorded that even agreeable informants would be hard pressed to provide an accurate and willing account. Kaufman claims that even "those who are sophisticated enough to appreciate the complexities of the subject and the obstacles to the truth do not try to describe it."[2] He continues, however, to stress the positive aspects of attempting to decifer the political processes inherent in health care decisions:

> In many a sensitive area patient, diligent discerning research has brought to light fuller, more balanced accounts of public policy formation than any single participant in the process could supply, and has both detected the unspoken customs and understandings involved in them and has analyzed the effect of these inarticulate premises of action on the final outcome.[3]

In any case, Kaufman claims that even though one view may not represent the truth, it will via the Socratic method elicit corrective commentaries which in total will provide significant insight into political intercourse.[4]

The base of political analysis in the health care field is fluidity of power relationships. The power structure is diffuse and decentralized, and, yet, it is these characteristics which are responsible for the prominance of health affairs in today's technocratic society. There has been a progressive decrease in the individual physician's power matched by a more prominant role for administrators and planners. Perhaps the greatest change, and the focus of this paper, is the vast politicalization of health policy issues with increasing political party, business, labor and consumer interest and involvement. This is best illustrated by the current proliferation of health bills, and the enormous expenditures of health lobbyists.

Pond, in an article delineating the politics of social change, underlines natural Congressional resistance to impulsive, unsupported, narrow programs without clearly defined relations to established goals. Elective officials, highly sensitive to the wishes of their constituencies, actively seek guidance from educated, well versed and trused professionals.[5] However, they even more vigorously seek to define the pitfalls in any proposed course of action because they themselves suffer the consequences of their decisions. Pond summarizes the successful politician's acumen:

> They recognize that there is no intrinsic virtue in any political position. Every policy decision derives from a complex of conflicting concepts of how to maintain a free and responsible society . . . they are familiar with the purposes of carefully drawn pro and con statements. In short, they are not easily swayed

by obviously self-serving clarion calls for action.[6]

It is obvious that even the most scrupulous, i.e., Wilbur Mills, is not above making errors. Witness the Medicare-Medicaid fiasco. Examples, such as the latter, make public officials even more reluctant to adopt "quick" solutions to what are obviously highly complex problems. The result, in the face of something like rising health expenditures, is increasing public frustration.[7]

Political motivations of individual committees or constituencies have to be considered in terms of what could be called Congressional mood. Maximum receptivity to change led to the enactment of Medicare-Medicaid in '65. Uncontrollable costs and the experience of certain states like New York (see Chapter I) led to 1967 restrictions by a cost-conscious Congress.

Background

With the 1969 entry of the Nixon administration, high expectations were initially deflated by administrative inaction. Then, on July 10, 1969 at a White House press conference, Nixon reinaugurated the hopes of health care progressives with his introductory remarks:

> We face a massive crisis in (health care) and unless action is taken, both administratively and legislatively, to meet the crisis within the next two to three years, we will have a breakdown in our medical care system.[8]

A July 1 ceiling (75%) on Medicaid providers and concurrent cancellation of the two percent "plus factor" in Medicare hospital reimbursements simultaneously marked the beginning of the end of federal tolerance for completely uncontrolled fees. In addition, Finch directed the newly appointed McNerney Task Force on Medicaid and Related Problems to suggest new directives for action. The years 1969 and 1970 became a period of high Congressional receptivity in which change was supposedly imminent at any time.

Fuel was added to the Nixon fire by the pro national health insurance recommendations of the Rockefeller dominated National Governor's Conference in September, 1969. Administration reaction was Finch's directive to the McNerney Task Force to study the problem of long term methods of financing the nation's medical care and to develop recommendations. It was in this aura that the Governor's Steering Committee was directed to tackle its report on health and hospital costs and services. The American Hospital Association's Perloff Committee simultaneously began its deliberations that September.

The urgency for change peaked somewhere between fall, 1969 and spring, 1970. However, Congressional receptivity did not truly subside until after the introduction of the administration proposal for a national health system on February 18, 1971. At this point there was a significant change in the political and economic climate which made prospects of massive governmental expenditures remote. There was no

possibility that an adequate universal health insurance program would be enacted.[9] This was accentuated by the President's wage-price freeze and continued by Phase II of the same.

The change in "government mood" was accompanied by the need for new strategies for reform. Comprehensive proposals such as the Kennedy, Griffiths', and Javits' ideas were considered obsolete.[10] Construction of the federal budget called for proposals which emphasized regulation rather than widespread reform. Regulation was of two types. Externally it could deal with centralized planning and stringently imposed controls (i.e., the limits of Medicaid reimbursemen) and internally could be fostered through increased competition among providers, the use of cost-effective incentives and the promotion of HMO's.[11]

The change in "government mood" necessitated strategy changes among proponents of health reform. Comprehensive bills,i.e., the Kennedy proposal, inevitably involved financial reform and were thus, inevitably, subject to the closed-mouth scrutiny of cost-conscious, budgetary minded Wilbur Mills. Those proposals, exclusively limited to changes in the delivery system, i.e., the administration HMO concept, could be directed to more receptive "health minded" committees such as the Senate Committee on Labor and Public Welfare. This favors fragmentation (i.e., no changes in delivery prior to changes in financing), but it is the most politically feasible approach. The latter is the "way to go" if one is interested

in reform in any way possible. Dr. Herman Somers explains:

> The point is that in the present circumstances it is far more possible to get substantial reform legislation enacted through the avenues of the health committees than through financial channels. And for the life of me, as one who feels that change in delivery methods is at least as important as new financing, I do not understand why that should be unnecessarily delayed by a self-imposed disability.[12]

Application

The genesis of the Rockefeller committee has already been described. Originally an eighteen month study was planned. After all, Congress was receptive and traditionally, for reasons outlined, avoided rushing. During the summer of '70, it became increasingly obvious that time was running out. The Administration proposed Medicaid reform in the June, 1970 Family Assistance Program. The June 30 McNerney report failed to recommend a national health plan but outlined a series of judgment criteria instead. The appearance of the Long Catastrophic proposal in the fall of '70 further stimulated the "core nucleus" to push for a product. Cohen had warned that the combination of The Family Assistance Program for the poor and Long's catastrophic plan was a very attractive alternative for pressured legislators. In any case federal budgetary contraction was imminent.

The need to move faster and faster was evident. The division of the group into sub-committees was scrapped. The

hearings were crowded into three rushed sessions and individual members (see Chapter III) were not permitted to suggest testifiers. By New Year 1971 the immediacy of the Administration's health proposal was frightening. A January 4th article by Richard Lyons of the New York Times reported that a Nixon "therapy" would be available in "late winter". Details were not then available, but the article related that the Administration would be well prepared, having held a "seemingly endless series of meetings examining the broadest and, perhaps, cheapest options that could improve the nation's health service."[13]

An alliance with the Administration was very important to the committee. It was obvious that Nixon's proposal, especially when enacted in its separate sections, was going to have a major impact on the Congress. An opportunity to influence the President's plan would be invaluable. In any case, Administration espousal of committee views would add to the report's political effectiveness.

There was also the Rockefeller-Nixon axis. Rockefeller had been quite involved in health matters since his Under-Secretary of Health appointment in the Eisenhower Administration. He had been trying to promote universal health insurance financed by employer-employee contributions for four years. With the assistance of Wilbur Cohen, he and Senator Javits had colloborated to produce the National Health Insurance and Health Improvements Act of 1970 (Javits bill 4/14/70-see Appendix D). In addition, since his November,

1970 election, and, perhaps before, Rockefeller had resolved his 1968 election differences with the President to the point where he is now currently rumored to be assured of a cabinet position in the event of a 1972 reelection. These improved relations were reflected in committee politics. White House aides were present at the initial conference and maintained communication with Mr. Weingarten throughout. The committee, in addition, had little trouble obtaining the testimony of HEW's Hess and Newman.

The point is that a Nixon-Rockefeller health alliance was mutually beneficial to both parties. Rockefeller would achieve his publicly stated goal of national universal health insurance. As a bonus, the program would, in several ways, simulate his New York State proposals. It promoted the growth of health maintenance organizations, utilized publicly controlled private carriers and was financed through employer-employee contributions. Nixon, on the other hand, would receive both the substantial support of the Governor and the elite of American business.

The committee completed its draft by the end of January. Conveniently, a February 11th meeting with Richardson and White House Staff was arranged on short notice. Victor Weingarten prepared a three page document of suggested points to be made with Secretary Richardson (revised at a short A.M. conference preceding the P.M. HEW meeting. Five major points were briefly described after it was made clear that the committee's deliberations were not yet completed: 1) the in-

timate interrelation between financing, organization and delivery; 2) the importance of consumer responsibility and health education; 3) incentives for restructuring the health care system with emphasis on prevention; 4) improvement of quality, quantity and distribution of manpower and 5) the removal of the financial barrier to adequate health care.

The hour long conference with Richardson and White House Staff focused on the administration plan. One of Richardson's staff described the plan prior to the Secretary's arrival at which time Mr. Richardson outlined the theory behind the administration's objectives and expressed satisfaction that the committee and administration agreed on most major points. The emphasis of his discourse was the need for federal leverage as opposed to government controls. There was strong reliability on a reinforced private sector. Neither the Secretary or his staff requested additional information about the committee's views or upcoming report. No differences of opinion were openly expressed by the eleven committee members present.

Several references to the Nixon plan appeared in the final report. The major remarks were highly favorable and reiterated the Fegruary 11 agreement on the need to use federal leverage for change:

> We are encouraged by the President's health care message to the Congress February 18, 1971 which recognized the principle of using new funds as a lever for change. We believe it has been one of the few times in recent years that Presidential emphasis has been on new and more effective methods of delivering care, instead of financing

> additional care. To that extent we welcome and support the President's approach.[14]

The final report openly expressed a minor difference with the Administration's February 18 message: its preference for an HEW situated National Center for Consumer Education. This was versus the privately financed and operated Health Education Foundation Nixon had discussed.

The report was made public at an April 15, 1971 luncheon attended by the Governor, The Steering Committee and a sampling of businessmen from the original May 14, 1970 Conference. A press release at that time emphasized the committee's recommendation for "sweeping reform of the health care system."[15] Governmental takeover was inevitable unless all new federal funding was used as a "lever for change." The remainder of the text was mostly a delineation of the summaries of findings and recommendations.

Press coverage was mostly limited to the New York area. The only national representation was organizations such as Associated Press. Most of the news media were exclusively interested in the Governor as opposed to Mr. Wilson or The Steering Committee. In fact, their main interest was not the committee findings or recommendations, but the Governor's concomitant revelation of impending legislation to establish incentives for non-profit medical corporations in New York State. The one local television station which filmed the luncheon devoted most of its footage to the Governor's remarks.

coverage assignment to a New York State health reporter versus Richard Lyons or Harry Schwartz who both cover the national medical scene. The Times headlined and emphasized the non-profit health corporations rather than the committee's report. The committee was hardly mentioned on the front page. It even misnamed the group calling it the Social Services Steering Committee. The emphasis of the article was so provincial that the reporter had to state "not just in New York, but throughout the country".[16] The remainder summarized the content of the report but made no attempt at analysis.

The major consequences of the committee's report were predictable in early January, 1971. In his State of the State message, the Governor commented:

> Based on a report of the Governor's Steering Committee on Social Problems to be available shortly, I expect to offer additional measures to increase the supply and availability of health professional personnel, including physicians.[17]

The 1971 session saw the enactment of a bill promoting the use of state created positions of physician's assistant and specialist's assistant under physician supervision.

More important and directly related to the committee was the September 14, 1971 creation of a new fifteen member committee on Health Education. Interestingly enough its chairman was Joseph P. Wilson, its director Victor Weingarten and two of its members Henry Smith and Walter J. McNerney. The committee's assignment was to recommend better ways to educate the public on how to keep well. It is

again interesting that the only openly verbalized criticism in the report was the need for an HEW consumer education center as against a privately controlled affair. The new committee has currently completed its fact finding and is now studying the feasibility of creating a national center for health education.

The Steering Committee, surprisingly enough did not testify at the House Ways and Means Committee's extensive hearings on National Health Insurance. Victor Weingarten, when questioned, replied that the "core nucleus" was too involved with its new function.[18]

Another interesting follow-up of the committee's eighteen month study was the appearance of Anne Somers' book, Health Core in Transition. It was published at committee expense in exchange for Mrs. Somers' ideas, which formed the core of the report. The only other notable financial consideration was Director Weingarten's salary. He received $57,000 for his efforts. This salary was greater than the total compensation for both the consultants and research assistants. Members of the committee were not reimbursed for their time.

The Governor's Steering Committee on Social Problems was deeply embroiled in the politics of health care. Nixon's July 10, 1969 health care message and the recommendations of the National Governor's Conference (September, 1969) had inflated expectations of health reformers and motivated the Governor to ask the Steering Committee to study the health

crisis. Throughout its study, the "core nucleus" maintained a close affiliation with White House aides and, on short notice, arranged a February 11, 1971 meeting with Secretary Richardson's White House staff. The publication of the Steering Committee's report was followed by the enactment of New York State manpower legislation and the appointment of a new "core nucleus" dominated federal commission on health education. The similarities between the Nixon proposal, the Steering Committee report and the Rockefeller philosophy were mutually beneficial to both the Albany and Washington constituencies. The April 15 report helped foster improved personal relations between the Governor and the President which, according to published rumors might result in a Rockefeller cabinet appointment.

The close friendship between chairman Joseph Wilson and the Governor was tragically illustrated by Mr. Wilson's untimely November 23, 1971 death while lunching with the Governor at his Manhattan office. The Governor referred to him as "a warm and dear friend; one of the truly great businessmen and creative leaders of our time".[19] The University of Rochester, of which he was chairman, closed all but essential services for one day as a tribute to a man whose "non-monetary contributions far outshadowed what he has given".[20] The President stated "Joseph C. Wilson exemplified, to an exceptional degree the ideal of a business leader with a public conscience".[21] Mr. Wilson, a young 61, was indeed truly motivated, friendly and endearing, but human as well. He was not above the political influences

which dominate day to day considerations and so markedly determined the course of the Governor's Steering Committee on Social Problems.

FOOTNOTES

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APPENDIX A

CONSULTANTS AND THOSE WHO TESTIFIED

APPENDIX A

PART A

CONSULTANTS

Dr. Martin Cherkasky
Director
Montefiore Hospital and Medical Center

Dr. Wilbur J. Cohen
Dean, School of Education
University of Michigan
Ann Arbor, Michigan

Dr. John Knowles
Director
Massachusetts General Hospital
Boston, Massachusetts

Mr. Herbert Lukashok
Assistant Professor
Department of Community Health
Albert Einstein College of Medicine
Bronx, New York

Mr. Walter J. McNerney
President
Blue Cross Association
Chicago, Illinois

Mr. Daniel Pettengill
Vice President, Group Division
Aetna Life Insurance Company
Hartford, Connecticut

Dr. George A. Silver
Director, Health Task Force
The National Urban Coalition
Washington, D.C.

Mrs. Anne R. Somers
Research Associate
Industrial Relations Section
Princeton University
Princeton, N.J.

Dr. George A. Wolf, Jr.
Professor of Medicine
College of Medicine
University of Vermont
Burlington, Vermont

APPENDIX A

PART B

LISTING OF PERSONS WHO TESTIFIED BEFORE STEERING COMMITTEE

Dr. Wilbur Cohen
Dean, School of Education
University of Michigan

Dr. Sydney R. Garfield
Founder
Kaiser-Permanente Medical Plan
Oakland, California

Dr. George Wm. Graham
Immediate Past President
American Hospital Association
Chicago, Illinois

Arthur E. Hess
Deputy Commissioner
Social Security Administration
Baltimore, Maryland

Dr. John Knowles
Director
Massachusetts General Hospital
Boston, Massachusetts

Walter J. McNerney
President
Blue Cross Association
Chicago, Illinois

Dr. George Melcher
President
Group Health Insurance of New York
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Howard Newman
Medical Services Administration
U.S. Department of Health, Education,
and Welfare
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Daniel W. Pettengill
Chairman
Health Insurance Industry Sub-
Committee on Health Care Financing
Hartford, Connecticut

Dr. Russell Roth
Speaker
House of Delegates
American Medical Association
Erie, Pennsylvania

Dr. George A. Silver
Executive Associate
The National Urban Coalition
Washington, D.C.

Arthur Weissman
Vice President and Director
Medical Economics
Kaiser Foundation Health Plan, Inc.
Oakland, California

Dr. Harold Wise
Director
Martin Luther King Jr. Health Center
Bronx, New York

Melvin A. Glasser
Assistant to the President
United Auto Workers Union
Detroit, Michigan

APPENDIX B

STEERING COMMITTEE ON SOCIAL PROBLEMS

Mr. Joseph C. Wilson: chairman of the Steering Committee, is Chairman of the Board of Xerox Corporation. He is a trustee of the Alfred P. Sloan Foundation and the Carnegie Endowment for International Peace. He is also a fellow of the American Academy of Arts and Sciences and a founding member of the Business Committee for the Arts. He is the recipient of honorary degrees from Notre Dame University, Le Moyne College, Boston University, Harvard University, St. John Fisher College and Springfield College. In June 1970, Harvard Business School honored Mr. Wilson with its alumni achievement award.

Mr. C. W. Cook: vice-chairman of the Steering Committee, is Chairman and Chief Executive of General Foods Corporation. A director of Whirlpool Corporation and Chase Manhattan Bank, he is also chairman and trustee of The Conference Board, a trustee of the Committee for Economic Development, The Council of the Americas, The Rockefeller University and Tuskegee Institute. He is also a member of the University of Texas System Development Board and the Visiting Committee of Massachusetts Institute of Technology's Department of Nutrition and Food Science. He has received honorary degrees from Babson Institute, Long Island University, Iona College, Pace College and Michigan Technological University.

Mr. Robert A. Bernhard: is Managing Director of Lehman Brothers, Inc. and a member of the Board of Directors of the Lehman Corporation. He is Vice President and Director of the One William Street Fund and a director of H.C.A. Industries. He is President of the New York Urban League and a Trustee of Montefiore Hospital and Medical Center, the Worcester Foundation for Experimental Biology and the Albert Einstein College of Medicine. He is a member of The Citizens' Commission on the Future of the City University of New York.

Mr. Harry B. Cunningham: is Chairman of the Board and Chief Executive Officer of S. S. Kresge. He is a director of Bendix Corporation, Warner-Lambert Pharmaceutical Company, Burroughs Corporation and National Bank of Detroit. He is also a director of the Detroit Symphony, Detroit United Foundation, Economic Club of Detroit, Metropolitan Fund, Inc., as well as a trustee of Junior Achievement, Citizens Research Council of Michigan and The Grace Hospital. He has received honorary degrees from Miami University, Hillsdale College and Tri-State College.

Mr. Joseph A. Dallas: is Vice President, Member of the Executive Committee and Board of Directors of E. I. duPont deNemours and Company. He is a member of the Board of Remington Arms Company, Inc. and of the American Institute of Chemical Engineers. He is Vice Chairman of the Board of the Wilmington

Medical Center, Vice President of Junior Achievement of Delaware and Director of the YMCA of Wilmington and New Castle County. Mr. Dallas is also a member of the Planning Council of the United Fund and Council of Delaware, and the National Advisory Board of the Opportunities Industrialization Center.

Mr. Harold E. Gray: was President and Chairman of the Board of Pan American World Airways Corporation. A former pilot, he helped to map out the routes which Pan Am pioneered across the Atlantic and Pacific. During nearly four decades of service, Mr. Gray has made major contributions in the aviation field, including the development of exact and continuous pilot training programs, the continuing development of stringent safety requirements and techniques, the development of rapid and accurate navigational methods and significant recommendations for improvement in aircraft design.

Mr. Michael E. Klein: is presently attending Yale School of Medicine as a candidate for the M.D. and M.P.H. He has prepared studies of the emergency systems of New Haven and Waterbury, Connecticut, as part of a public report of the Waterbury Comprehensive Health Planning Commission. In addition, Mr. Klein organized and is a director of a New Haven community based organization manned by youth which provides 24-hour consultation service for drug addicts, runaways and youth in distress.

Mr. Philip M. Klutznick: is Chairman of the Board of the Urban Investment and Development Company, Chicago, as well as a director of several corporations. He served as Representative of the United States to the Economic and Social Council of the United Nations, with the rank of Ambassador in 1961-1962, and was a member of several delegations to the General Assembly of the United Nations receiving special assignments here and abroad by appointment of Presidents Eisenhower, Kennedy and Johnson. Mr. Klutznick is a member of the Board of Governors of the Metropolitan Housing and Planning Council of Chicago and a trustee of several educational institutions. He has received honorary degrees from Creighton University, Wilberforce College, Dropsie College, Hebrew Union College, Chicago Medical School, the College of Jewish Studies and Hebrew Theological College.

Mr. R. Heath Larry: is Vice Chairman of the Board of Directors of U.S. Steel Corporation. He is also Chairman of the Board of Directors of the Bituminous Coal Operators Association, a member of the Communications and National Affairs Coordinating Committee of the American Iron and Steel Institute and board member of the Highway Users Federation for Safety and Mobility. He was appointed by President Nixon as a member of the National Commission on Productivity. Among his other activities, Mr. Larry serves on the boards of the YMCA of Pittsburgh, St. Clair's Memorial Hospital, is a member of the Board of Visitors University of Pittsburgh Law School, and is a trustee of Grove City College and the U.S. Council of the International Chamber of Commerce.

Mr. Harvey Russell: is Vice President of Community Affairs, Pepsico, Inc. He is a member of the New York State Board of Social Welfare, a director of the National Municipal League, Region II Boy Scouts of America, and is Vice Chairman of the African American Institute. In the past Mr. Russell served as a trustee of the Adoption Service of Westchester, State Communities Aid Association, Inter-Racial Council for Business Opportunity, the OEO Business Leadership Advisory Council, and the U.S. State Department Advisory Council for African Affairs. He was also a director of Tougaloo College and the National Alliance of Businessmen.

Mr. Samuel J. Silberman: is President of Gulf & Western Foundation. He is a member of the New York State Temporary Commission to Revise the Social Services Law, and Chairman of the Coast Guard Academy Foundation. A past President of the Federation of Jewish Philanthropies of New York, Mr. Silberman is currently President of the Greater New York Fund, Fairleigh Dickinson University, the National Committee for Social Work Education and the American Social Health Association. He serves in various capacities with numerous other public purpose organizations.

Mr. J. Henry Smith: is President of the Equitable Life Assurance Company, Fellow and member of the Board of Governors of the Society of Actuaries and is also Director of the American Academy of Actuaries, and the International Congress of Actuaries. He serves on the Board of the Chase Manhattan Bank, the Economic Development Council of New York, the New York Urban Coalition, the Methodist Hospital of Brooklyn, the New York Heart Association and the United Fund of Greater New York. Mr. Smith is also Vice Chairman of the Board of Alfred University. He has received honorary degrees from Alfred University and the University of Delaware.

Mr. Gustave L. Levy: was former Chairman of the Board of Governors of the New York Stock Exchange. He is a partner in the firm of Goldman Sachs and Company, and is a director of many industrial and business organizations. He is Chairman of the Mount Sinai Hospital and Medical Center, Treasurer of Lincoln Center for the Performing Arts, a member of the Board of Visitors of Tulane University, as well as a member of the Board of Tulane Medical Center. He is Chairman of the Board of Federation of Jewish Philanthropies of New York, Director of the Museum of Modern Art and a member of the Visiting Committee of the UCLA Graduate School of Business Administration. He is a recipient of honorary degrees from Syracuse and Tulane Universities.

Mr. Baldwin Maull: was Chairman of the Board of Marine Midland Corporation and recently retired as Chairman of the Board of Social Welfare of New York State. A director of several corporations, Mr. Maull has been affiliated with numerous community organizations. In 1965 he headed the New York State Citizens Committee on Welfare Costs and earlier had served on the Moreland Act Commission on Public Welfare. He is currently an Associate Trustee and member of the Board of Law of the University of Pennsylvania and a member of the Board of Visitors of Berry College. He was granted an honorary degree by Niagara University.

Mr. Arjay R. Miller: is Dean of the Graduate School of Business at Stanford University. He was formerly president of the Ford Motor Company. He is chairman of the Urban Institute of Washington, D.C., and is a trustee of the Brookings Institution, the Committee for Economic Development, and the Conference Board. He did not participate in this study.

Mr. Alfred C. Neal: is President of the Committee for Economic Development, New York City. An Economist and Research Executive, he is a director of the President's Commission on International Trade and Investment Policy, a board member of the Education Development Center, Hampshire College and the Institute of Public Administration. A former Vice President of the Federal Reserves Bank at Boston, Mr. Neal taught economics at Brown University, and is the author of several books in that field.

Mr. C. W. Owens: is Executive Vice President of American Telephone and Telegraph Company. He is a director of W. R. Grace and Company, Metropolitan Life Insurance Company and director and member of the Executive Committee of Marine Midland Banks. Mr. Owens is a director of Boston College and is Vice President of the New York Chamber of Commerce and Chairman of the Executive Committee of St. Vincent's Hospital and Medical Center of New York. He served as President of the New York Traffic Safety Council, and was a director of the Welfare Island Development Committee.

APPENDIX C

PARTICIPANTS

GOVERNOR'S CONFERENCE ON HEALTH AND HOSPITAL SERVICES AND COSTS

May 14, 15, 1970

*Member, Steering Committee

ALLEN, G. B.
Associate Director
Hospital Association

ALTSCHUL, Arthur
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General American Investors Company, Inc.

ANDERSON, Robert B.
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Loeb, Rhoades Company

*BERNHARD, Robert A.
General Partner
Lehman Brothers

BINGER, James H.
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Honeywell, Inc.

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BRISCO, Milo M.
President
Standard Oil Company

BROWN, Gordon E.
Executive Director
State Communities Aid Association

BUTLER, Lewis H.
Assistant Secretary
For Planning and Evaluation
Department of Health, Education,
and Welfare

CARNEY, Robert F.
Chairman, Finance Committee
Foote, Cone & Belding Communications, Inc.

CAVANAUGH, Dr. James H.
Deputy Assistant Secretary
for Health & Scientific Affairs
U.S. Department of Health, Education,
and Welfare

CHASE, Edward T.
Editor-in-Chief
The New American Library, Inc.

*COOK, C. W.
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General Foods Corporation

*CUNNINGHAM, Harry B.
Chairman of the Board
and President
S.S. Kresge Company

DALLAS, Joseph A.
Vice President (and member of the
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ECCLES, Marriner S.
First Security Corporation

EDGERLY, William S.
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Cabot Corporation

ENTHOVEN, Dr. Alain
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Litton Industries, Inc.

FINKE, Walter W.
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Dictaphone Corporation

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Hospital System Studies
Battelle Memorial Institute

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GAVIN, Gen. James M.
Chairman
Arthur D. Little Company

GILLESPIE, S. Hazard
Davis, Polk, Wardwell,
Suderland and Kiendl

GOTBAUM, Victor
Executive Director
District Council 37
American Federation of State,
County and Municipal Employees

GRAHAM, Katharine (Mrs.)
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The Washington Post Company

*GRAY, Harold E.
Chairman
Pan American World Airways

GROESCHEL, August H., M.D.
Chairman of the National Health Resources
Advisory Committee
Executive Office of the President

GUINAN, Matthew
President
Transport Workers Union

HALLSTEIN, D. Wayne
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HAMILTON, John A.
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The New York Times

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General Manager
New York Joint Board
Amalgamated Clothing Workers of America

HOLMES, Walter S., Jr.
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C.I.T. Financial Corporation

INGRAHAM, Hollis S., M.D.
Commissioner
Department of Health

IVES, Martin
Deputy Comptroller
State of New York
Department of Audit and Control

JASPER, David W.
Vice President and General Counsel
Carrier Corporation

JAVITS, The Honorable Jacob K.
United States Senator

KIMBALL, Lindsley F.
Rockefeller Brothers Fund

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Professor, School of Journalism
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KINGSTON, The Honorable John E.
Majority Leader of the Assembly

KLEIN, Michael E.
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School of Medicine

*KLUTZNICK, Philip M.
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Urban Investment and Development Company

LARRY, R. Heath
Vice Chairman
U.S. Steel Corporation

LENT, The Honorable Norman F.
State Senator
Chairman of the Standing Committee on Health

*LEVY, Gustave
Goldman, Sachs and Company

LINDSEY, Edward G.
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State Communities Aid Association

McCLOSKEY, Francis P.
Assemblyman
State of New York

McGOWAN, Harold
President
Endicott Johnson

*MAULL, Baldwin
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Marine Midland Banks, Inc.

MAY, William F.
Chairman
American Can Company, Inc.

MILLER, Dr. Alan, D.
Commissioner of Mental Hygiene

MILLER, Otto N.
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Standard Oil Company of California

MOSCOSO, Teodoro
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Commonwealth Oil Refining Company, Inc.

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Morgan Guaranty Trust Company of New York

MOYNIHAN, Daniel P.
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The White House

*NEAL, Alfred C.
President
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NELSON, Dr. Russell
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The Johns Hopkins Hospital

NEWTON, J. Quigg
President
The Commonwealth Fund

OWENS, C.W.
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New York Telephone Company

PEACH, Robert
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Mohawk Airlines, Inc.
Oneida County Airport

PERKINS, Donald S.
President
Jewel Companies, Inc.

PETTENGILL, Daniel W.
Chairman
Committee on Medical Economics
Health Insurance Association of America

PRICE, John
Director
Urban Affairs Council

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Vice President
National Industrial Conference Board

RENCHARD, William S.
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Chemical Bank New York Trust Company

REUTHER, Walter
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Staff Assistant
The Carnegie Corporation

ROGERS, Talmage
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Cummins Engine Company, Inc.

*RUSSELL, Harvey C.
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PepsiCo, Inc.

SAUNDERS, STUART T.
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Penn Central Company

SCHIFF, Frank
Vice President and Chief Economist
Committee for Economic Development

SEIBERT, E.H.
Vice President
The Parker Pen Company

SANKER, Albert
President, Local 2
United Federation of Teachers

*SILBERMAN, Samuel J.
Chairman
Gulf & Western Foundation

SIMON, Norton
President
Hunt Foods & Industries, Inc.

SLATER, Joseph Elliott
President
The Salk Institute

SMILEY, Donald B.
Chairman
R.H. Macy & Company, Inc.

STEPHENS, The Honorable Willis H.
Chairman
Assembly Ways and Means Committee

THOMAS, O. P.
President, Chief Executive Officer
Sinclair Oil Corporation

VAN NESS, Edward H.
Executive Director
New York State Health Planning Commission

WAHMAN, Thomas W.
Rockefeller Brothers Fund

WARTER, Dr. Peter
Department Manager
Xerox Corporation

WERNER, Jesse
Chairman and President
GAF Corporation

WILKIE, John
Chairman
Central Hudson Gas & Electric Corporation

*WILSON, Joseph C.
Chairman
Xerox Corporation

WILSON, Richard J.
Cosmac Buildings Supply Corporation

WYMAN, The Honorable George K.
Commissioner
New York State Department of Social Services

YOUNG, Thomas G.
Local 32-B
Service Employees International Union

ZARETZKI, The Honorable Joseph
Senate Minority Leader

APPENDIX D

SUMMARY OF NATIONAL HEALTH PLANS

AMERICAN MEDICAL ASSOCIATION'S MEDICREDIT PLAN*

SUMMARY

Tax credits for voluntary purchase of qualified private health insurance, with federal purchase of insurance for "the poor." Retains Medicare, absorbs part of Medicaid.

ELIGIBILITY

All individuals and families actually or potentially subject to federal income taxes may elect to be covered under Act, except for persons covered by Medicare and members of Armed Forces.

ANNUAL BENEFITS

A. Minimum required insured benefits (subject to co-payment and deductibles):

Institutional services

60 days in-hospital care, including maternity, with all customary services.

Emergency room or outpatient services billed for by hospital.

Medical services

All medical services wherever provided.

B. Optional or supplemental coverage (subject to co-payment and deductibles):

Prescription drugs.

Additonal days of inpatient hospital services.

Cost of blood furnished.

*As presented to House Ways and Means Committee, November 3, 1969.

Other personal health services provided by licensed practioner under order of a physician.

FINANCING

Via Tax Credits and Federal Subsidy

Those electing coverage under Act to be granted income tax credits against actual cost of health insurance coverage, amount of credit depending on amount of tax liability. Maximum credit: 100% of premium for qualified medical care insurance policy, allowed to persons with tax liability of $300 or less. As tax liability increases, credit allowance gradually reduced: $501 tax, 70% credit; $701 tax, 45% credit; $1,001 tax, 20% credit; tax of $1,300 or more, 10% credit.

People with little or no tax liability to receive payment vouchers for purchase of qualified health insurance policy, vouchers to be redeemed by insurance companies from federal funds appropriated for that purpose. Vouchers may also be issued to persons eligible for Medicare and used to pay premiums for supplementary insurance (Medicare Part B).

Tax credit allowable on more than one qualified policy to extend duplicate coverage avoided. If credit taken as above, medical expense deduction disallowed for income tax purposes.

Co-payment and Deductibles

Inpatient hospital services: $50 deductible for each hospital stay

Emergency and outpatient services: 20% co-payment on first $500 of expenses

Medical services: 20% co-payment for first $500 expenses Supplemental coverage.

Drugs: $50 deductible per year

Additional hospital days, blood, other personal services: 20% co-payment.

MANAGEMENT AND ADMINISTRATION

Create Health Insurance Advisory Board

Membership: Secretary of HEW (Chairman), IRS Commissioner, 9 nongovernmental members appointed by President with consent of Senate, to serve four year term and be paid per diem for attending meetings, conferences, etc.

Duties: prescribe regulations, establish minimum federal standards for qualification of insurance plans, develop programs for maintaining quality of care and effective utilization of resources, make annual report to Congress.

State insurance departments are to: (1) determine qualifications of carriers to offer acceptable medical care insurance policies and register them; (2) approve plans for base or minimum coverage using national standards; (3) approve premium rates; and (4) contract with HEW, if state desires, to obtain insurance coverage for all Medicaid eligibles in state.

Individual carriers (voluntary associations, corporations, partnerships or other nongovernmental organizations) are to offer approved policies to all applicants regardless of preexisting health conditions and on a renewable basis.

ORGANIZATION AND DELIVERY OF CARE

No changes suggested.

METHODS AND RATES OF REIMBURSEMENT

No changes suggested.

THE AETNA PLAN*

SUMMARY

Voluntary health insurance for poor and related groups via private insurance pools, with federal and state financial aid. Also, government financed catastrophe medical expense coverage for population at large. Retains Medicare, replaces Medicaid.

ELIGIBILITY

Minimum uniform health benefits program (voluntary as among states) for persons under age 65 who are:

Poor, i.e., families with incomes below federally defined level, uniform for all states.

Near-poor, i.e., families with incomes above the "poor" level but below federally determined amount, uniform for all states.

Self-employed who are uninsurable (except at excessive rates) because of poor health.

Catastrophe medical expense program:

Entire population, to be phased in starting with poor, then near-poor, then balance.

ANNUAL BENEFITS

Minimum uniform health benefits under program (neither deductibles nor co-payments mentioned)

Institutional services:

31 days in-hospital care, semiprivate room, usual services.

60 days in skilled nursing home.

*As presented to House Ways and Means Committee in November, 1969, by Daniel Pettengill, Vice President, Aetna Life and Casualty Company.

90 home care services provided as part of approved home care program.

All necessary physician's services in connection with covered institutional care.

Medical services:

Physical exam, biannually for those 8-64 years old, annually for children under 8.

Necessary immunizations for children under 8 and for pregnant women.

Twelve visits to physician
Surgery and anesthesia
Radiation therapy
Diagnostic X-ray exams and lab tests

Performed in office or ambulatory care center.

Dental services (only for children ages 8 through 14):

Annual prophylaxis and necessary fillings.

Catastrophe medical expense program

Provides government (federal and state) payment for annual medical expenses in excess of family responsibility, amount of responsibility (deductible) determined annually by size of family and gross income. Exact levels to be set by Congress in enabling legislation. Examples: family of 4 with gross income of $10,000 responsible for up to $6,100 of medical expenses (their deductible); same family with $6,000 gross income responsible for $2,100; family earning $3,000 not responsible for any medical expenses. Allows for phasing

in, starting with poor, and for federal specifications of eligible expenses.

FINANCING

Purchase of minimum benefits package (from insurance pool)

Poor: premiums to be paid by federal and state governments. States obligated to cover any family on public assistance (if state elects to participate in program).

Near-poor: pay percentage of premium based on adjusted gross income in eligibility year. Percentage to be nominal near bottom of income class, rising to full cost at upper limit of class.

Uninsurable: pay rate higher than standard but lower than otherwise available.

Federal and state contribution: amount equal to excess of premiums charged by pool over contributions made by near-poor and uninsurables. Federal share to be 65-90%, depending on per capita income of state vs. United States as whole (sharing rate least in states with highest income). Benefits above minimum may be provided by state but sharing rate somewhat lower.

Catastrophe medical expense program

Cost to be shared by federal and state governments, federal sharing rate to be 75% of rate applicable in state for minimum benefits program.

MANAGEMENT AND ADMINISTRATION

National Advisory Health Council

Membership: to be appointed by President to represent consumers, state health administrators, etc.

Functions: advise President about major health care problems, recommend priorities for allocating available funds, suggest appropriate agencies to be extended, programs to be revised or discontinued.

Comprehensive Community Health Planning Agencies

Should be given mandate to (a) determine and assign priorities among community's health needs; (b) review all proposals requiring large capital outlays, certify degree of need; and (c) review all requests for government loans and grants, advise on need and priority.

State Reinsurance Pools

To provide the uniform plan of health insurance benefits for poor, near-poor, etc., a reinsurance pool is to be underwritten by all licensed health insurance carriers in state (profit and nonprofit). Plan is to be operated like a group plan with all administration performed by one carrier (or set of carriers) chosen by the state with concurrence of Secretary of HEW. All carriers to share losses, be allowed appropriate risk charge for assuming risk. Premium to be set annually by administering carrier with advice and consent of actuarial committee appointed by Governor.

ORGANIZATION AND DELIVERY OF CARE

Promote development and use of comprehensive ambulatory care via:

1. Federal loan guarantees to encourage construction of ambulatory care centers.
2. Federal loans to cover set-up costs, grants instead of loans to be made for centers in poverty areas.
3. Inclusion of ambulatory care benefits in all government health insurance programs.
4. Penalties against employers for not including such benefits, after a reasonable period, in group medical plans.[1] Suggests employer be allowed to deduct for federal income tax purposes only 50% of medical benefit expenses (instead of present 100%).

Provide additional health manpower via:

1. Consolidation of all federal loan-grant programs for health manpower into single program.
2. Student loans for full cost (tuition, room, board, etc.) of medical, dental, other health training considered in short supply by Secretary of HEW.
3. Waiver of one tenth of total (student) loan for each year served in area of need, e.g., rural or inner-city, as designated by Secretary of HEW.
4. Federal grants to medical schools for devising curricula and securing faculty to train primary care physicians and/or administrators of health centers.

METHODS AND RATES OF REIMBURSEMENT

Methods of reimbursement of providers by carriers:

No changes from existing arrangements suggested.

Rates of reimbursement of providers by carriers under all federal programs:

Hospital services: to be paid for only on a "controlled charges" basis, no payment to be made unless institution uses controlled charges for all its patients. System requires annual estimates of budget, establishment of charges that should produce income assumed by budget. Budget and charges subject to review and revision by board of consumers, insurers, health care institutions. Also, payments will be made only to institutions having an effective review committee of qualified physicians.

Medical services: no payment of portion of fee in excess of prevailing level of fees in community. Also, effective peer review of services required, no payment made for services found to be unnecessary.

[1]Proposal seeks to set certain standards for existing employment-related health insurance programs, penalizing programs that don't conform. All are to include the minimum recommended benefits package and cover part-time, temporarily unemployed, sick, and disabled employees, for specified periods of time.

THE ROCKEFELLER PLAN*

SUMMARY

Mandatory private health insurance for employees and their dependents; optional coverage for self-employed and unemployed. Retains Medicare, absorbs part of Medicaid.

ELIGIBILITY

Coverage required for:

All full-time and some part-time employees and their dependents except those eligible for Medicare or members of specified groups (federal, railroad, maritime workers, clerics, casual or seasonal employees, etc.).

All self-employed individuals with covered workers.

Coverage optional for:

Self-employed individuals without covered workers.

Short-term unemployed (30-180 days after termination of employment).

Long-term unemployed:

Public assistance recipients.

Medicaid eligibles.

ANNUAL BENEFITS

Institutional services:

90 days in-hospital care, including psychiatric.

Outpatient hospital services.

Diagnostic X-ray, lab services, emergency accident care, minor surgery, radiation and physical therapy, psychiatric services up to $500.

*A state plan introduced to the Senate of New York State on April 1, 1970.

Maternity benefits: hospital and/or physician up to $150.

Home care: hospital sponsored or related, up to 100 visits per year (beginning within 14 days after hospitalization).

Medical services (subject to co-payment provisions):

Visits to office, clinic, outpatient department for diagnostic X-ray, lab services: emergency accident care, minor surgery, radiation and physical therapy.

Optional benefits:

Private nonprofit prepayment plans would be required to offer the following to those choosing such coverage:

a. Inpatient and ambulatory medical, surgical, and psychiatric services provided on a prepayment basis by hospitals or by approved group practices, and/or

b. Medical and surgical hospital services (inpatient psychiatric up to $650) with $50 deductible and 20% co-payment.

FINANCING

Full-time and some part-time employees

Employee:

If annual wage $6,000+, pay 35% of insurance premium.

If annual wage $5,000-$6,000, pay 20% of insurance premium.

If annual wage less than $5,000, pay nothing.

Employer pays at least 65% of premiums but does not have to pay a total of more than 4% of his covered payroll.

State pays missing portions

a) Premium sharing: 15% of premiums for those earning $5,000-6,000, and 35% of premium for those earning less than $5,000.

b) Assistance to employers: assist employers whose premium cost exceeds 4% of total covered payroll.

Individuals unemployed 30-180 days: Individual pays 50%, state pays 50% of premium.

Long-term unemployed (public assistance recipients and Medicaid eligibles):

Premiums to be paid by existing federal, state, and local programs though Medicare left intact. Each social services district is to assure coverage to each eligible from specified carrier or group of carriers.

Co-payments and Deductibles

Medical services: all covered physicians' services subject to a $2 co-payment provision. (Routine physical exams are specifically excluded from coverage.)

MANAGEMENT AND ADMINISTRATION

Creates New York State Health Insurance Corporation (the Corporation) and Regional Medical Councils to administer program.

The Corporation

Membership: 12 trustees, 7 appointed by Governor to represent specified interest groups (consumers, hospitals, health professionals), plus Commissioners of Health, Social Services, and Commerce, Superintendent of Insurance to serve ex-officio. Twelfth member appointed by others to be Executive Director and Secretary. Consumer representative may be salaried, others not.

Functions:

1. Approve, for carriers (a) hospital rates and medical fees

to be paid; (b) premium rates, as provided by law; (c) rules for determination of rates by commercial carriers; (d) rules for determination of rates for experience-rated contracts; (e) insurance coverages.

2. Administer system, make rules, etc., including approval of benefit variances, i.e., benefit plans of actuarial and health equivalence.
3. Make arrangements to provide insurance coverage for persons receiving public assistance, eligible for Medicaid, or unemployed.
4. Administer state's contribution to premium cost.
5. Approve prepayment charges of group practice plans.
6. Supervise nonprofit insurance corporations.
7. Appoint Regional Medical Councils (at least 7).

Regional Medical Councils

Membership to be 9, at least 3 representing consumers, 2 purchasers of health services. Function is to establish schedules of fees for region, subject to approval of Corporation. Public hearings may be held.

ORGANIZATION AND DELIVERY OF CARE

Stimulate formation of group practice arrangements and other corporate forms for (prepaid) provision of comprehensive health services.

1. Nonprofit Medical Corporations: statutory barriers eliminated so physician and hospital can unite to provide

comprehensive services on prepayment (or fee-for-service) basis, enter into contracts with insurers of health benefits. Such corporations are to be granted non-profit tax status and made eligible for state loans for hospital construction or modernization, as well as state funds for start-up costs.

2. Professional Health Service Corporations: provide for incorporation under Business Corporation law for any type of (licensed) professional medical service.

Increase public control of nonprofit health insurance corporations.

1. Increase public representation on Boards of Directors of such corporations, e.g., Blue Cross, Blue Shield, HIP.
2. Provide for visitation and supervision by the new Health Insurance Corporation with power to make recommendations on quality, efficiency and public responsiveness of services rendered.

METHODS AND RATES OF REIMBURSEMENT

Cost of Coverage

Premium cost for minimum benefits package: premium rate of non-profit insurance corporation must be approved by the Corporation. Experience rating permitted for groups of 50 or more. Nonprofit corporations are required to provide minimum package and optional benefits as demanded; commercial carriers have option of doing so.

Methods and Rates of Reimbursement of Providers by Carriers

Hospital and health-related service rates: must be certified by Commissioner of Health and approved by the Corporation. Rates are to be "reasonably related to costs of

efficient production of such services," taking into account geographic differentials, economy of area, costs in hospitals of comparable size, need for incentives to improve services, make economies, etc. Hospitals and carriers may review proposed rates.

Medical fees: fee-for-service or prepaymennt. Rates to be established by Regional Councils with approval of the Corporation. Upon approval, carriers may not pay more nor provider charge more. Basis on which fees are to be established not stated.

Group practice prepayment plans: charges to be approved by the Corporation.

THE FELDSTEIN PLAN*

SUMMARY

Universal major risk medical coverage provided by federal government, plus government-guananteed postpayment loans. Retains Medicare, terminates Medicaid.

ELIGIBILITY

Everyone in the United States.

BENEFITS

Comprehensive coverage, subject to large deductible (see below). Extent of coverage not defined beyond "comprehensive" except for reservation that very expensive treatments, e.g., kidney dialysis, could be included or excluded (via ceiling on benefits) as desired. Also, might except certain preventive care and early diagnostic tests from deductible provision to encourage their use.

FINANCING

Major Risk Insurance (MRI)

To be provided by federal government and paid out of general tax revenues.

Deductible provisions:

Alternative 1: A single deductible on all medical expenditures covered by MRI that is "large in comparison to average family spending on

*Martin S. Feldstein, National Health Insurance: A New Approach (Mimeo, 1970).

health care but low relative to family income." Suggests deductible be adjusted for family size and age composition as well as income. Illustrative example sets expense limit (deductible) at 10% of income up to a maximum deductible of $800. Families below poverty line would be given, in addition to MRI, a cash grant equal to their expected health spending. With such a deductible, "the vast majority of payments for physician and hospital services would not be covered by insurance."

Alternative 2: Would add coinsurance feature without changing amount of family's maximum risk exposure. Example: 10% deductible replaced by basic deductible of 5% (of income) followed by 50% coinsurance for additional 10% of income.

Would eliminate need for Medicaid and suggest end to income tax deductions for medical expense. Medicare would continue in its current form.

Government-Guaranteed Postpayment Loans

People who could not immediately pay their direct expense obligations could obtain federally guaranteed loans enabling them to spread payment over a period of a year or more.

MANAGEMENT AND ADMINISTRATION

No particular administrative system described for MRI program. Federal government would apparently handle all claims. However, those people exceeding their expense limits would submit only one claim per year, greatly reducing administrative

expense as compared with multiple claims under present private insurance arrangements. (Proposal asserts that current types of "shallow" coverage provided by private health insurers will be eliminated or at least greatly reduced.)

Government would also have to administer loan guarantee provision, but no administrative system described.

ORGANIZATION AND DELIVERY OF CARE

No specific changes recommended. Proposal states: "Organizational changes that might increase efficiency with which medical care produced, e.g., group practice and use of paramedical personnel, would be encouraged under MRI by natural pressure from patients (seeking) to obtain care at lower cost. ... If automatic responses do not produce sufficient innovations, direct subsidies could be introduced."

METHODS AND RATES OF REIMBURSEMENT

No changes recommended. Proposal says that since most medical care is to be paid for by patient directly, patients will be impelled to choose, with physician's advice, most efficient combination of resources to obtain care (ambulatory services, paramedical personnel, etc.). Doctors, hospitals, others would, in consequence, become more cost conscious. Need for specific regulations on rates and methods of reimbursement, therefore, not considered necessary.

THE JAVITS PLAN*

SUMMARY

Converts Medicare, with expanded benefits, into national health insurance plan for entire population. Absorbs most of Medicaid.

ELIGIBILITY

Eligibility to be extended in several steps:

Step 1. Cover all citizens and aliens with 5 years residence, aged 65 and over; all persons receiving disability benefits; widows 60 and over; widowers 62 and over, by July 1, 1971.

Step 2. Cover all resident citizens and aliens regardless of age by July 1, 1973.

ANNUAL BENEFITS

Benefits also to be extended in several steps.

Initial benefits package: Medicare Parts A and B combined.

Hospital services (subject to present deductibles and copayment)

90 days for each "spell of illness" plus 60 day "lifetime reserve." Lifetime limit on psychiatric hospital services: 190 days.

100 days for each "spell of illness" in extended care facility, following hospital stay of at least 3 days.

*Introduced to Senate by Senator Javits on April 14, 1970 as S.3711--National Health Insurance and Health Improvements Act.

100 home health visits after hospital stay and before next "spell."

Medical services (subject to present deductibles and co-payment)

Physicians and surgeons services in office, hospital, clinic, home, etc., including usual services and supplies. (Maximum outpatient psychiatric benefit limited to $250 per year.)

100 home health services without prior hospitalization.

Diagnostic tests, including lab and X-ray; radiation therapy.

Ambulance services.

Prosthetic devices, rental beds, other equipment.

Steps in extension of benefits

Step 1. Extend Medicare Part B benefits automatically to all those eligible for Part A, i.e., eliminate monthly Part B premium. Apparently to take effect when bill approved--no date mentioned.

Step 2. Add a drug benefit, with cost sharing provisions, to cover long-term maintenance drugs used to treat diabetes, chronic cardio-vascular diseases, kidney conditions, respiratory conditions, to take effect July 1, 1973.

Step 3. Add coverage of an annual physical exam, including eye and ear, and routine dental care for all children under age 8, to become effective July 1, 1974. (No cost sharing or deductibles)

FINANCING

Via Social Security Program

Employee Self-employed Employer (on covered payroll)	On $15,000 earnings base	Each to contribute at rate of: 1971: 0.7% 1974: 3.1% 1972: 0.9% 1975 forward: 3.3% 1973: 2.0%

Federal government to contribute 50% of above amount from general revenues, i.e., about one third of total annual fund.

Co-payment and Deductibles

Provisions as at present under Medicare A and B (1970)

Hospital services: deductible $52, co-payment $13/day for 61st-90th day of hospitalization, $26 per day on lifetime reserve days.

Extended care facilities: after first 20 days, patient pays $6.50/day.

Physicians' services, other Part B benefits: deductible $50, co-payment 20% of "reasonable charges" plus 100% of "excess charges," if any.

Provisions for new benefits

Drug benefit: co-payment of $1, to be adjusted by per capita cost changes.

Physical exam: coverage limited to $75.

MANAGEMENT AND ADMINISTRATION

No major changes from present Medicare administration: private insurance carriers to continue to play major role.[1]

[1]To improve on past performance, Bill requires all carriers administering Medicare to continually study organization and delivery in their areas of operation, review patterns of utilization, effectiveness of procedures for controlling utilization, and make changes to improve controls.

However, changes possible if HEW and states exercise following new powers conferred by Bill.

1. Secretary of HEW authorized to establish one or more federal health insurance corporations for administration in those areas where efficient private carriers cannot be found.
2. Secretary of HEW authorized to contract directly with "comprehensive health care service systems" for provision or program benefits to specified populations.
3. States may, if they wish, participate in administration of all or part of program via agreement with Secretary. Costs of carrying out agreement to be paid to states by Secretary.

Drug benefit (new)

Requires Secretary of HEW to determine reasonable drug charges, establish and maintain list of drugs approved for coverage. Is to appoint 5-member committee of experts to advise on policy, determine drugs to be added to or deleted from list.

ORGANIZATION AND DELIVERY OF SERVICES

Bill seeks to establish pluralistic health insurance system with various types of federally approved private options. Present Medicare "system" of organization and delivery left intact but other possibilities offered and one encouraged particularly. In addition to present Medicare system, options are:

1. Employer-employee plans

Employer, with approval of employees, may provide health care benefits if he has a qualified plan approved by Secretary of HEW. To be qualified, plan must (a) provide benefits in conjunction with insurance carrier or union-management health plan, (b) provide employer contribution of at least 75% of cost, (c) cover employees and their dependents, and (d) provide benefits superior to those covered under Act. Applicable payroll tax suspended for those utilizing this option.

2. Private insurance plans

Private carriers, under contract with Secretary of HEW, may offer national or regional plans which provide protection equivalent to national program at no more than comparable cost. Must be available to all individuals (in a specified area) except for approved restrictions to avoid undue adverse selection.

3. Comprehansive health care service systems

Definition. A system for providing health care to all (enrolled) residents in a geographically defined primary service area and its environs on basis of group practice contractual arrangements among providers. Must furnish health services at least as comprehensive as those provided by Act, without co-payment or deductibles, except as authorized by Secretary. Enrollment may be limited in number and restricted to prevent undue adverse selection, but must seek to include broadest possible range of income and social

groups. Must encourage health education of members, use of preventive health services, be subject to review by approved group of physicians, train and employ allied health personnel, encourage community involvement. Initial establishment must be approved by state planning agency.

Role. May contract directly with Secretary of HEW for provision of services to specified population. May also contract with private insurance carriers, other providers of health services.

Measures to stimulate formation of systems.

HEW may pay 80% of cost of planning and developing plan, also provide technical assistance.

For 5 years, HEW may pay that portion of administrative, operating, and maintenance costs which exceeds income of system.

HEW may assist in construction and modernization of facilities via loans and grants, also subsidize interest payments on mortgages covering facilities.

METHODS AND RATES OF REIMBURSEMENT

Payments to be made on basis of "appropriate and reasonable charges" rather than "reasonable charges" only. Otherwise to remain unchanged from present Medicare regulations (at least temporarily), with following exception.

Payments to comprehensive health service systems. At option of system, Secretary may pay either (a) reasonable cost of services or (b) predetermined capitation amount (estimated average reasonable cost). If cost and quality warrant, may also make incentive payment (up to two thirds of costs saved when compared with national program).

Future methods of reimbursement. Act orders immediate study by Secretary of HEW to discover reimbursement system best able to control costs and utilization, improve organization and delivery, emphasize health maintenance, etc., yet give providers "fair and reasonable compensation." Secretary is to consult widely with various interested groups and, thereafter, with approval of President, suitably modify reimbursement methods and amounts by act effective July 1, 1973.

THE GRIFFITHS PLAN*

SUMMARY

National health insurance program, offering comprehensive benefits, to be administered by federal government agency and financed via payroll taxes plus federal general revenues. Terminates Medicare and Medicaid.

ELIGIBILITY

For hospital and medical benefits: every man, woman, and child who has resided in the United States for one year or more, except active duty service men.

For dental benefits: all children under age 16.

ANNUAL BENEFITS

Institutional services: as required, subject to co-payment provisions

Inpatient hospital services: usual services, diagnostic and therapeutic services, private nurse, physicians' services (medical and surgical) with certain exceptions.

Outpatient hospital services.	When furnished by, or on referral of, a hospital or a physician.
Skilled nursing home services.	
Home health services.	
Rehabilitative services.	
Ambulance services.	

*Introduced by Congresswoman Martha Griffiths as H.R. 15779 on February 9, 1970.

Medical and related services: as required, subject to co-payment provisions

Primary physicians' services,[1] including preventive care and physical exams.	
Specialist physicians' services.	When furnished on order of primary physician.
Outpatient psychiatric services.	
Optometric services and eyeglasses.	
Outpatient diagnostic, screening services.	
Prescription drugs.	
Prosthetic devices, durable medical equipment.	

Dental services: virtually all services, as required.

FINANCING

Via Social Security Program

Employer: pay 3% of covered payroll	On specified earnings base rising from present level to $15,000 annually by 1975.
Employee: pay 1% of wages	
Self-employed: 4% of self-employment income	

Federal government: match employer contribution from general revenues, in lieu of all current federal, state and local expenditures for health services, including Medicare and Medicaid.

Co-payment and Deductibles

Physician's services: $2 per visit except for one physical exam and first visit for treatment of illness or injury.

[1]General or family practitioner, internist, pediatrician, or gynecologist. Patient's point of entry into system.

Other medical services: $2 per visit except for optometric services, outpatient diagnostic and screening services.

Dental services: $2 per visit except two annual exams or prophylazes and first visit for dental disorder.

Home health services: $2 per visit.

Eyeglasses, prosthetic devices, durable equipment, dentures: an allowance to be established.

Total deductible is not to exceed $50 per individual or $100 per family per year.

MANAGEMENT AND ADMINISTRATION

Creates National Board and special-interest Advisory Councils to regulate operation of program, as well as Regional groups to administer and advise.

National Health Insurance Board

Membership: 9 members, 6 appointed by President, to represent specified interest groups (3 medical care, 1 management, 1 labor, 1 provider) and to be full-time salaried members ($38,000). Also 3 ex-officio members--Secretary of HEW (to be Chairman of Board), Assistant Secretary for Health and Scientific Affairs, and Commissioner of Social Security. Staff as required.

Functions: establish health regions and appoint regional administrator, make regulations and set standards including the establishment of capitation rates, disburse funds to regions and, if necessary, contract for the provision of health services or for health services research.

National Health Professions Council and National Health Benefits Council

Membership: 20 on each Council, appointed by President, to represent interests of providers and consumers. Chairman of Board to be Chairman of both Councils; members to be paid per diem.

Functions: propose and review, at least annually, range of national capitation rates for medical, dental, and hospital services; advise Board on policy; make recommendations to improve delivery systems.

(Office of) Regional Administrator

Regional Administrator appointed by Board, authorized to set up office and hire people as necessary to carry out functions. Duties:

1. Enter into contracts with providers of medical, dental, hospital services.
2. Keep a record of patients on the lists maintained by those providing primary medical or dental services.
3. Allocate funds to assure availability of needed services in all areas of region.
4. Stimulate health education of public, continuing education of health personnel.
5. Adjudicate complaints.
6. Develop plans for construction of facilities and development of manpower, also for improving quality and delivery of care.

Regional Consumer and Professional Advisory Committees

Membership: 12-24 members on each, appointed by Regional Administrator to represent various consumer interest (poor, minority groups, labor, farmers) and professional interests (physicians, nurses, hospitals, nursing homes, etc.). Per diem payment.

Functions: Make recommendations re solution to problems, maximizing effectiveness of program. Both to have full-time professional staffs. Professional Committee shall also (a) review and appraise performance on agreements for furnishing health services and (b) evaluate quality of care in region.

ORGANIZATION AND DELIVERY OF SERVICES

Medical groups or individual physicians (or dentists) contract with regional agency to provide primary care and to assume responsibility for securing specialist care as needed for their patients. People eligible for benefits annually select the participating (primary) physician or dentist of their choice and register on his list.

Hospital services can be provided in same way, via contract with regional agency: besides in-hospital care, participating hospitals are to provide, or arrange and pay for, skilled nursing home care, home health services, and rehabilitation services.

Formation of groups to provide comprehensive care encouraged by financial incentives, planning grants, funds for staff and facilities.

METHODS AND RATES OF REIMBURSEMENT

Methods of Reimbursement

Providers of primary care to be paid by regional agency (a) on a per capita basis, amount determined by number of individuals on practitioner's list, (b) on a salary basis, whole or part time, or (c) some regionally approved combination of (a) and (b).

Hospital services to be paid (a) by capitation, (b) on the basis of budgeted costs (to be defined by regional agency in regulations), or (c) on an approved basis providing incentives for improving quality and efficiency.

Providers of comprehensive services to be paid sum of per capita amounts payable for each service (medical, dental, hospital) separately plus 5% of capitation for administrative expenses.

Group practice may reimburse its members by fee-for-service, in addition to capitation or salary as above. Group also eligible for 5% capitation bonus if it arranges for a system of peer review, improves efficiency of delivery, and provides for continuing education.

Rates of Reimbursement

Range of capitation rates to be established annually by National Health Insurance Board. On basis of rates and factors affecting utilization, Board makes capitation payment to each health region.

Medical and dental service payments: may be varied by

regional agency for (1) local differences in cost of providing services, (2) differences in experience of practitioners, (3) age, sex distribution, and extent of morbidity of population served. Capitation rate must permit physician to pay for needed specialist and other licensed health professionals.

Hospital payments: capitation rate may be varied with (1) area cost differences, (2) nature and scope of services provided, (3) quality of services. Must be sufficient to permit provision or purchase of skilled nursing home care, home health services, rehabilitation services.

COMMITTEE FOR NATIONAL HEALTH INSURANCE--KENNEDY PLAN*

SUMMARY

National health insurance program, offering comprehensive benefits, to be controlled and administered by HEW and financed via taxes on wages and other income, plus federal general revenues. Terminates Medicare and Medicaid.

ELIGIBILITY

All U.S. residents, including aliens admitted as permanent residents.

ANNUAL BENEFITS

Institutional services (no co-payments or deductibles)

All necessary hospital services, without limit, except for psychiatric (45 days per spell of illness).

120 days skilled nursing home care per spell of illness.

Home health services.

Other approved institutional services.

Medical services (no co-payments or deductibles)

All necessary physician's services with some restrictions on psychiatric care. (No restrictions on latter if provided by comprehensive health service organization or other approved institution. If not so provided, covered services limited to 20 consultations per spell of illness.)

*Originally sponsored by Committee for National Health Insurance in their Health Security Program, Health Care for all Americans, July 7, 1970. Introduced to Senate, with minor modification, by Senator Edward Kennedy on August 27, 1970, as S.4297.

Optometrists, podiatrists, others.

Supporting services.

Dental services

At start, dental benefits (prophylaxis, diagnostic, therapeutic, and rehabilitative services exclusive of most orthodontia) limited to children up to age 15. Age eligibility to increase by two years of age annually until all under 25 covered. Extension to others as rapidly as practical.

Drugs and other benefits

Prescribed drugs covered for those in comprehensive group practice plans, in-patients, certain out-patients; other persons covered only for specified chronic illnesses or conditions requiring long expensive therapy.

Therapeutic devices, appliances (including eyeglasses), etc., subject to limited total expenditures.

Ambulance services

Mental day care (with some restrictions)

FINANCING

Via tax on wage and other income plus federal general tax revenue proportioned as follows:

25% from employed and self-employed individuals (2.1% tax on adjusted gross income--wage and nonwage--on earnings base of $15,000)..

35% from tax on employer-payroll (3.5% payroll tax).

40% from federal general revenues.

Tax rate might need adjustment from time to time but proceeds

are to be total sum available for personal health services in each year, less amounts set aside for contingency reserves (sum not specified) and Resources Development Fund. Latter to gradually rise from 2% to 5% of total available for obligations in the year.

Medicare to be terminated. Medicaid could be used, at option of states, to provide benefits not covered by program, e.g., long-term nursing home care, adult dental care, other medicines. Benefits which are available under program would be withdrawn from Medicaid.

Co-payments and Deductibles

None for covered benefits.

MANAGEMENT AND ADMINISTRATION

Program to be administered by HEW through national, regional, sub-regional, and local Health Security Offices.

Health Security Board (National)

Membership: 5-member, full-time salaried Board appointed by President for 5-year terms and serving under Secretary of HEW. President to designate Chairman, Board to appoint, from outside, and executive Director to administer program.

Duties:

Establish policy and, with approval of Secretary, issue regulations.

Allocate and control expenditures from Trust Fund.

Establish national benefit patterns.

Assure availability of services.

Establish national standards for participation by individual and institutional providers, e.g., continuing education requirements, Board certification.

Administer Resources Development Fund (see below).

Gather and evaluate performance data, sponsor studies.

Assure consumer participation at all levels.

National Health Security Advisory Council

Membership: Chairman of Board plus 20 members appointed by Secretary for four years. Members are to represent consumers (majority) and providers, be paid per diem.

Functions: advise Board in development of policy and regulations, and allocation of funds.

Resources Development Fund

Purpose: improve availability and delivery of services covered by program.

Activities: stimulate formation of comprehensive group practice programs; expand training programs for categories of health professionals and allied health workers in especially short supply and in new categories of need; support training of minority groups and poor in health field; improve organization and delivery systems; develop services to meet changing needs.

Financing: first by Federal appropriation, then by a percentage of the annual Health Security Trust Fund (2-5% a year).

Regional Offices of Health Security[1]

Assess regional needs, coordinate planning and funding to meet those needs.

Approve institutional budgets.

Approve providers for participation in program.

Act as payment authorities, if desired (use of intermediaries not required).

Assure expenditures contribute to efficient development of facilities, manpower, and delivery systems.

Regional Advisory Councils

Council of consumers (majority) and providers to advise regional representative of Board on all matters relating to administration of program in its area.

Area or Subregional Offices

Coordinate expenditures of funds with approved regional and local plans formulated by planning agencies.

Provide technical assistance to providers, states, and communities.

Monitor application of quality standards.

Help institutions in development of their annual budgets.

Local Offices

Act as citizen ombudsman.

Help community define its health priorities.

Assist in planning to meet area needs.

ORGANIZATION AND DELIVERY OF SERVICES

Formation of comprehensive prepaid group practice plans to be encouraged via:

[1]HEW presently divides the United States into 10 regions.

a. Grants and loans from Resources Development Fund. Plans allow grants of 80% for planning and development costs, 90% loans for construction and equipment, and payment of operating deficits for specified periods.

b. Preferential treatment in payment for services (See Methods of Reimbursement below).

Special training programs for physicians, dentists, allied health workers to be funded. Also, financial and other incentives applied to move health manpower into medically deprived areas. New methods of organizing health services to be supported experimentally.

State comprehensive health planning agencies to be funded and strengthened. For example, hospitals and nursing homes must get state approval for new construction or expansion to remain eligible for participation in program.

METHODS AND RATES OF REIMBURSEMENT

Board to divide money available nationally (the Health Security Trust Fund) among and within regions. Each year, Board will make advance determination of total amount to be spent in each region and how sum is to be allocated among physicians' services, institutional services, other categories of services provided. Initially, money to be divided on basis of latest regional expenditure figures; subsequently, division would be modified to (1) reduce differences in per capita expenditures among regions, (2) distribute resources throughout

regions as needed, (3) reflect regional planning recommendations, (4) stress preventive care, use of noninstitutional forms of care, and (5) increase efficiency of system.

Regional and local Health Security offices are to make direct payments to providers for their services, with funds made available by Board, as follows:

a. Hospitals, nursing homes, other institutions
To be reimbursed on basis of prior (approved) budget. Utilizing experience of past year, institutions are to develop budgets for next fiscal year, have them reviewed and approved by Regional Office.

b. Physicians' services (doctors, dentists, podiatrists, etc.)
Money allocated to region for physicians' services to be distributed to local areas on per capita basis with modification for various relevant factors. After meeting contractual obligations to salaried physicians in institutions, group practice plans, etc., and to physicians accepting capitation payments for care of defined population, physicians' allotment remaining thereafter to be used to pay all fee-for-service bills. If available funds not sufficient to cover all fees in full (on basis of negotiated fee schedules) payment to be prorated.

c. Comprehensive group practice plans (providing or arranging for all covered services or, at a minimum, all services except institutional care, mental health and dental services.

To be paid a per capita fee which has been budgeted and negotiated in advance. May share in savings achieved via reduced hospitalization rates (75% of amount saved).

PLANS PROPOSED AFTER CONFERENCE

HEALTH INSURANCE ASSOCIATION OF AMERICA PLAN*

SUMMARY

Income tax credits to employer groups and individuals for voluntary purchase of qualified comprehensive private insurance. Retains Medicare; Medicaid replaced by private insurance pool for poor, near-poor and uninsurable.

ELIGIBILITY

U.S. residents. Members of Armed Forces, other persons covered by direct government-financed services not eligible but could be made so under special rules as to enrollment and risk sharing.

ANNUAL BENEFITS

Minimum Standard Healthcare Benefits--to be phased-in over six-year period, eventually to include following (all subject to copayment and deductible provisions):

Institutional services per illness (including psychiatric):

300 days in-hospital care; semi-private room, usual services.

180 days nursing home care.

270 days home care, if part of approved program.

Medical services:

Physician's services. Without limit, on both in-patient and out-patient basis. Includes necessary tests (lab, X-ray, EKG), surgery, family planning services and supplies, periodic physical exams, well-baby care.

*As published in Program for Healthcare in the 1970's, Health Insurance Association of America (Mimeo. 1970). Largely embodied in H.R. 19935 introduced by Representative Burleson on December 10, 1970.

Optometric services. Periodic exams and purchase of glasses (benefits vary by age).

Dental services (phased-in by age groups):

Annual exam and prophylaxis; amalgam filling, extraction, dentures; other care except orthodontia.

Drugs and miscellaneous benefits:

All prescription drugs and others approved by Secretary of HEW.

Physical and speech therapy; prosthetic devices.

FINANCING

Persons covered by employer-employee health plans

Financing to continue as at present. If plan includes all features of Minimum Standard Healthcare Benefits, employer's expenditures 100% deductible for income tax purposes. If plan does not meet Minimum, expenditures only 50% deductible. (Proposal does not require employer to provide coverage; it remains optional.)

Individuals with adequate resources not eligible for group coverage

Encouraged to purchase own Minimum Benefits via same tax incentive as above.

Individuals with inadequate resources and uninsurables (to be covered by private insurance pools)

Poor, i.e., those below specified income levels varying with family size.[1] For example, family of 3 or more earning

[1]Income level could vary by states or within states, or be uniform for all states. Income is gross adjusted income. To establish eligibility for free or subsidized health insurance, a simple report of total income for prior year is to replace "means tests."

less than $4,000. Premiums to be paid entirely by federal and state funds. Participation voluntary but state obligated to include any family receiving cash assistance.

Near-poor, i.e., those falling within specified income range varying with family size. For example, family of 3 or more earning $4,000-$6,000. Family to pay graduated amount rising from zero at bottom of range ($4,000) to a maximum of 6% of income at upper limit of range ($6,000).

Uninsurables. Each to pay full premium charged state for coverage of a single individual; no direct government subsidization.

Federal and State Contributions

Amount equal to difference between total cost of premiums and contributions made by near-poor and uninsurables. Federal share to range from 90% for poorest states down to 70% for states whose per capita income equals or exceeds national average. After specified date, states without approved plan ineligible for Federal money under Title V (Maternal/Child Health Programs) and Title XIX (Medicaid).

Co-payment and Deductibles

Institutional services. In-patient hospital: $10 first day, $5 per day thereafter. Nursing home and home care: $2.50 per day.

Medical services. Physician's services: $2 per visit in office or ambulatory care center, $5 at home. For mental conditions, insured pays 50%.

Optometric services. For people 19 or older: 50%

Dental services. Filling, extractions, dentures: 20%. Other care: 50%.

Drugs. $1 per prescription.

Rehabilitative services. Insured pays 20%.

No deductibles for poor, near-poor, uninsurables. Total annual co-payment for them limited to 6% of income on which premium contribution is based, or $30, whichever larger. (Family of 3 earning $6,000 has contributory income of $2,000: maximum co-payment would be $120.) For all others covered by an approved plan, aggregated amount of co-payments and deductibles per family limited to $1,000 per year.

MANAGEMENT AND ADMINISTRATION

Council of Health Policy Advisors

Membership: three full-time members appointed by President with consent of Senate.

Functions: assist President in preparation of annual health report; make national policy recommendations to improve organization, financing, delivery and quality of health care; conduct research; provide guidelines for allocation of health funds; recommend procedures for coordination or elimination of inter-agency programs.

State Healthcare Institutions Cost Commission

Appointed by Governor of each State to (1) approve charges made under any program supported by federal funds for health services rendered in hospital or other health institution,

(2) require all institutions to have an active review committee, use standard system of accounts and cost finding.

Federal government to pay 75% of operating costs of each State Commission.

Comprehensive Health Planning Agencies

State Health Planning Agencies: with respect to proposed new services, facilities, and equipment, certify need for and priority of all applications for federal grants and loans in excess of $100,000. Could reverse decision of areawide agency re grants and loans (after public hearing) or act if areawide agency fails to do so.

Areawide Comprehensive Health Planning Agencies: would have strong consumer representation, be responsible for determining community's health needs and assigning priorities, coordinating facilities and programs, educating community. Also, certify need and priority on all federal loan and grand applications of $100,000 or more; assist all health facilities plan their capital expenditures in ways consistent with state health plan.

To finance planning, one tenth of one percent of total national personal health expenditures "should be provided."

State Insurance Pools

To provide each state with a Qualified State Healthcare Plan to cover poor, near-poor and uninsurables, all licensed private health insurance carriers--profit and nonprofit--required to form insurance pool, with one carrier or group of

carriers chosen by state, with approval of Secretary of HEW, to administer plan. Pool losses, if any, would be limited, with excess losses borne by state and federal governments.

ORGANIZATION AND DELIVERY OF SERVICES

No major changes suggested. Makes health maintenance organizations eligible to provide coverage. Calls for encouragement of comprehensive ambulatory care centers via federal grants and loan guarantee to construct and equip them, and to subsidize their costs (administrative, operating, and maintenance) for first three years.

Manpower and Distribution

Student Loan Program. Improve such programs so students may borrow at reasonable rates full cost of tuition, books, room, board, etc. Cancel 20% of loan for each year served by physician, optometrist, dentist in "an area of need," e.g., inner-city. Cancel 33 1/3% of loan for each year served by nurses and allied health personnel in "area of need," or 20% of loan per year (only up to half its value) for each year of service in the profession. As temporary measure, provide federal grants to get professionals to serve in areas of priority need.

Training Program. Provide schools with federal grants to secure faculty for training of additional physicians and allied health personnel in the skills of providing family health care on ambulatory basis or administering ambulatory care centers.

METHODS AND RATES OF REIMBURSEMENT

Hospital or Other Health Care Institution. Under any program supported by federal funds, charges must be approved by State . . . Cost Commission. Each institution must have active review committees, use a standardized system of accounts and cost finding. Also required to use "prospectively approved charges," i.e., advance budgeting wherein charges "reasonably related to cost of efficient production." Commission to review and approve budget, take into account geographic variations, costs of comparable institutions, capital requirements, need for incentives, etc. Capital costs to be included in budget only for expenditures approved by appropriate health planning agency.

Medical Services. No major changes suggested. No payment to be made for any services found to be unnecessary as defined by professionally established utilization guidelines, nor for any fees in excess of prevailing level of charges in community.

Does offer bonuses to physician providers in "pool" (for poor, etc.). Fifty percent of any experience credits, not to exceed 4% of premiums, to be available as bonuses to encourage economical pool performance.

AMERICAN HOSPITAL ASSOCIATION'S AMERIPLAN*

SUMMARY

Benefits incentive plan for voluntary purchase of basic health insurance coverage and use of group practice prepayment plans. Social Security tax used to finance basic coverage for elderly and catastrophic coverage for all except poor. Federal general revenues to finance same coverage for poor. Would absorb Medicare and Medicaid.

ELIGIBILITY

U.S. residents. (To be eligible for Health Care Maintenance and Catastrophic Illness benefits package, must have purchased or been provided with Standard Benefits Package and must be registered with Health Care Corporation.)

ANNUAL BENEFITS

1. Standard Benefits Package (Prerequisite for second package)

 Institutional benefits (total of 180 days, subject to 10-20% deductible):

 90 days in hospital, including care for tuberculosis, alcoholism, drug addiction, and psychiatric care. Usual services.

 30 days in extended care facilities
 90 days in nursing home
 } Could be increased by credit for unused hospital days.

 100 home health visits

*From Report of a Special Committee on the Provision of Health Services, American Hospital Association, Ameriplan (American Hospital Association, Chicago, Illinois, 1970).

Medical services (subject to 10-20% deductible):

Diagnostic and treatment services wherever provided. Generally, same benefits as available on in-patient basis.

Drugs (on ambulatory basis, subject to annual dollar limit):

Prescription drugs as listed in national formulary.

2. Health Maintenance and Catastrophic Illness Benefits Package

Health Maintenance Benefits:

Immunizations, well-baby care, dental services for children (prophylactic and therapeutic), multiphasic screening, electrocardiograms, pap smears, rectal examinations, physical examinations for patients with positive findings.

Catastrophic Illness Benefits:

All health expenditures beyond deductible without limit except for nursing home care (90 days), custodial care in extended care facility (30 days), TB, mental illness (completely excluded).

Size of (single) deductible determined by income and size of family, their health expenditures. The poor eligible for benefits immediately after Standard Benefits exhausted. Persons with higher income would have to expend predetermined amount before eligible, but could purchase supplemental coverage to fill gap.

FINANCING

Direct private purchase of Standard Benefits Package by all except poor, near-poor, aged, from private insurance companies and prepayment plans on voluntary basis.

Social Security tax on all employed or self-employed persons used to finance (a) Standard Benefits package for aged, and (b) Health Maintenance and Catastrophic Package for all except poor and near-poor.

General federal revenues to finance both packages of care for poor, part of packages for near-poor.

MANAGEMENT AND ADMINISTRATION

National Health Commission

An independent agency.

Membership: 5-7 full-time, salaried commissioners appointed by President to serve staggered terms, e.g., 6 years. Support of professional staff.

Functions: adopt regulations to create benefit packages stating scope, quality, and comprehensiveness of services; establish requirements for providers; review activities of State Health Commissions; determine revenue requirements for tax-supported health benefits; administer trust fund; contract for purchase of benefits financed through federal funds (can delegate to states); coordinate activities of voluntary and federal agencies; periodically report to President on progress of Ameriplan; advise on legislative amendment.

State Health Commission

A new independent commission.

Membership: 5-7 full-time, salaried commissioners appointed by Governor for staggered terms, e.g., 6 years. Professional staff.

Functions: generally, regulate the formation and operation of Health Care Corporations (HCC's), including approval of rates charged for services. Specific functions include designation of geographic area and populations to be served by each HCC; assurance that benefits packages (quality as well as quantity), meet federal requirements; approval of facilities planning and construction; establishment of appeals and review mechanisms. (Could delegate certain operational functions to Regional Commissions.)

State Bureau of Health Financing

Either new or existing agency to regulate premium structure of pre-payment plans and health insurance companies, validate need, collect and disperse federal funds for health care of poor and near-poor.

Regional Health Commissions

If population size and geographical areas warrant, Regional Commissions could be established to carry out certain operational functions of State Commission.

Health Care Corporations (HCC's)

Private organizations responsible for provision of com-

prehensive care to designated community or population, network of HCC's to cover entire country. See "Organization and Delivery of Care" below.

ORGANIZATION AND DELIVERY OF SERVICES

Plan seeks to promote establishment of Health Care Corporations via benefits incentive, i.e., to be eligible for Health Maintenance and Catastrophic Illness Benefit packages, available only through HCC's, person must be registered with HCC, have received Standard Benefits package from same (or similar) HCC. Suggests federal loans and grants be provided to aid formation and initial operations of HCC's.

Health Care Corporations

New, with local, regional, or national sponsorship. Privately organized and operated HCC's would have direct responsibility for delivering comprehensive care (health maintenance, primary, specialty, restorative, and custodial care) to community designated by State Health Commission. Network of HCC's to cover every geographic area and all of population; everyone eligible and encouraged to join. (Several HCC's might have same geographic assignment.) HCC's would ordinarily be formed by existing provider organizations using existing facilities as base and own financial resources, but could be local government authority or private corporation. Could contract with other providers for services HCC unable to produce. Participation open to all qualified physicians, would permit various forms of practice including group practice.

HCC's would be responsible for quality, quantity, and effective delivery of (federally mandated) health care benefits; for continuity of care through ambulatory, in-patient, extended, and home care services; for recruitment and in-service education of its health manpower; for liaison with other health agencies; for research; for receipt and payment of funds for health services; for grievances. Are to be oriented to maintenance of health, prevention of illness, and to emphasize ambulatory care.

Governing Board. Each HCC to have a governing board with ultimate responsibility and authority. Composition to be determined by HCC. Accountability to registrants required but consumer representation on board optional.

METHODS AND RATES OF REIMBURSEMENT

Health Care Corporations. Initially to be paid on basis of prospectively determined rates as approved by State Health Commission except maintenance benefits to be paid by capitation. After sufficient experience accumulated, annual capitation payments should be adopted for all (comprehensive) services provided by HCC's; best incentive to economy. Capitation or prospective rates should cover necessary capital funds for facilities but should not cover costs of training health care personnel or medical research. Latter two must be financed from other sources.

Providers. HCC's would negotiate with and pay providers "on an equitable basis": could be fee-for-service, capitation, salary, salary plus bonus, or combination.

PRESIDENT NIXON'S NATIONAL HEALTH INSURANCE PLAN*

SUMMARY

Mandatory private health insurance for employees and their dependents including nationally established (minimum) benefits and catastrophic coverage. Much of Medicaid replaced by federal purchase of coverage for poor but certain groups remain under Medicaid. Medicare retained.

ELIGIBILITY

All U.S. residents except members of Armed Forces, civilian federal employees, and selected others.

ANNUAL BENEFITS

Minimum Benefits and Catastrophic Coverage under National Health Insurance Standards Act. (Required under all employer-employee plans except for state and local government, self-employed, domestics, part-time and seasonal workers)

Minimum Benefits:

Institutional services:

In-hospital or equivalents in extended care facilities or home health services. (No day limit mentioned.) Deductible: patient pays first two days bed and board. Co-payment: 25%

Medical services (25% co-payment):

Physicians and surgeons services wherever provided.

Diagnostic X-ray and lab work, in-patient or out-patient.

*As released by the White House on February 18, 1971.

Well-child care, including immunization, and maternity care (no deductible on either, no waiting period on latter); vision care for children.

Drugs:

Covered for in-patients only.

Limitations on total deductibles and co-payments:

Deductibles limited to $100 per person up to three (so maximum is $300 per family) plus two days hospital room and board charges (average $54/day currently).

Co-payment (25% of costs) limited to $5,000 in covered medical expenses per person, i.e., limit of $1,250 per family member. Once $5,000 reached in year, no further coinsurance for that person for that year and two succeeding years.

Catastrophic Coverage:

After co-payment limit reached, there is catastrophic coverage of $50,000 per family member during life of policy contract, with automatic restoration of $2,000 in benefits each year after full benefit "used up."

Family Health Insurance Plan (for uncovered poor families with children, e.g., unemployed, intermittently employed, self-employed)

Provides minimum benefits package listed above except in-hospital services (or their equivalent) limited to 30 days.

FINANCING

National Health Insurance Standards Act

Employer-Employee Plans. Employer to pay 75% of costs, employee 25% after 1976. Between initiation of program (July 1973) and 1976, employer to pay 65%, employee 35%. No federal contributions.

Persons Not Eligible for Group Plans (self-employed, small employers, people outside labor force, "uninsurables"). Requires formation of private insurance pools to offer coverage at group rates to individuals and small groups. Prohibits cancellation after costly illness.

Family Health Insurance Plan (FHIP)

Replaces Medicaid for eligibles.

Poor. Defined to be families with children whose income falls below nationally defined limits, e.g., family of 4 with income of $3,000 or less; family of 11 with $9,000 or less. (Income could be from self-employment and/or welfare.) Federal government would pay for coverage (and administer program). No deductibles or co-payment for poor.

Near-poor. Defined to be families with children having incomes just above limits set for poor, e.g., family of 4 with $3,000 to $5,000 income. Would pay a graduated schedule of premium charges, deductibles, and co-payments, amount rising as income rises. Difference between premium cost and family contribution covered by federal funds.

State Contribution. Relieved of bulk of Medicaid costs by FHIP (above) but encouraged to supplement FHIP benefits via federal assumption of administrative costs on consolidated federal-state benefits package. Current Medicaid program to continue for poor in following categories: individuals and families (without children) under age 65; blind and disabled; persons over age 65.

Medicare

To continue as at present except Part B premium to be prepaid in combination with Part A. To finance prepayment, the contribution rate will be raised .1% (from 1.0% to 1.1%) and the maximum earnings base increased from $9,000 to $9,800.

MANAGEMENT AND ADMINISTRATION

No new administrative structures or agencies suggested. Provision of required coverage left to insurance companies, Blue Cross, Blue Shield, Health Maintenance Organizations (HMO's), self-insurers, etc. (Carriers would have to offer subscribers option of enrolling in HMO's--whenever available--in addition to traditional fee-for-service coverage.) FHIP apparently to be handled on basis similar to Medicare.

ORGANIZATION AND DELIVERY OF SERVICES

Health Maintenance Organizations (HMO's)

An HMO is defined to be "an organized system of health care providing comprehensive services (ambulatory and hospital

care at a minimum) to a voluntarily enrolled population for a fixed prepaid fee." Plan seeks to promote widespread development of HMO's in following ways: federal planning grants ($23 million) to potential HMO sponsors (private and public); federal loan guarantees ($300 million) for construction, coverage of operating deficits; removal of state barriers to prepaid group practice; federal contracts with HMO's to provide services to Medicare, Medicaid, FHIP eligibles electing such programs.

Resource Development

Plan calls for variety of programs, old and new, to increase supply of health manpower and training facilities, and to improve the geographic distribution of health care resources. All programs require special funding--none is an integral part of the National Health Insurance Plan itself. The main proposals are:

Manpower and Facilities. Capitation grants of $6,000 per graduate to schools of medicine, dentistry, osteopathy ($93 million); special project grants for enrollment increases and curriculum shortening ($118 million); scholarship program for low-income and minority students ($29 million); expanded loan program for students; expanded programs for training allied health personnel, especially physicians' and dentists' assistants, nurse pediatric practitioners, nurse midwives ($29 million); new guaranteed loan program to support construction of medical education facilities ($500 million).

Distribution. Compensate professionals for serving in scarcity areas via forgiveness of portions of student loans; mobilize a new National Health Service Corporation to support 660 professionals in areas of need ($10 million); encourage formation of HMO's in scarcity areas via grants and loans ($23 million); establish Health Education Centers for teaching, providing sophisticated medical service not otherwise available ($40 million).

METHODS AND RATES OF REIMBURSEMENT

No direct changes recommended.

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